Local Coverage Determination (LCD): Therapy and Rehabilitation Services (L33413)

Contractor Information

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LCD Information

Document Information

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CMS National Coverage Policy

Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

- CMS Manual System, Pub. 100-01, Medicare General Information, Eligibility, and Entitlement, Chapter 4, Physician Certifications and Recertification of Services
- CMS Manual System, Pub. 100-02, Medicare Benefit Policy, Chapter 7, Home Health Services; Chapter 12, Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage; Chapter 15, Covered Medical and Other Health Services
- CMS Manual System, Pub. 100-03, Medicare National Coverage Determination, Chapter 1, Part 2, Section 160.12; Part 4, Section 270
- CMS Manual System, Pub. 100-03, Medicare National Coverage Determination, Chapter 1, Part 4, Section 270.6
- CMS Manual System, Pub. 100-04, Medicare Claims Processing, Chapter 5, Part B Outpatient Rehabilitation and CORF Services
- CMS Manual System, Pub. 100-04, Medicare Claims Processing, Chapter 5, Section 20.4
- CMS Manual System, Pub. 100-02, Medicare Benefit Policy, Chapter 15, Sections 220-230
- CMS Manual System, Pub. 100-04, Medicare Claims Processing, Chapter 5, Sections 10.2-10.6
- CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.7
- CMS National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 11, Section H, Otorhinolaryngologic Services
- Program Memorandum AB-00-53, Change Request 577, June 2000
- Program Memorandum AB-00-120, Change Request 1419, December 2000
- Program Memorandum AB-02-156, Change Request 2314, November 2002
- Program Memorandum AB-02-161, Change Request 2313, November 2002
- Program Memorandum AB-03-093, Change Request 2733, June 2003
- Transmittal 59, Change Request 2937, November 2003
- Transmittal 5, Change Request 2859 and 2779, February 2004
- Transmittal 805, Change Request 4226, January 2006
- Transmittals 46, 139, and 853, Change Request 4364, February 2006
Transmittals 60, 171 and 1106, Change Request 5271, dated November 9, 2006
Transmittals 62 and 1127, Change Request 5421, dated December 15, 2006
Transmittals 63, 181 and 1145, Change Request 5478, dated December 29, 2006
Transmittal 1407, Change Request 5871, dated January 10, 2008
Transmittal 245, Change Request 5945, dated February 29, 2008
Transmittal 88, Change Request 5921, dated May 7, 2008
Transmittal 1678, Change Request 6321, dated February 13, 2009
Transmittal 1691, Change Request 6397, dated March 4, 2009
Transmittal 1851, Change Request 6660, dated November 13, 2009
Transmittal 1850, Change Request 6719, dated November 13, 2009
Transmittal 828, Change Request 7300, dated December 29, 2010
Transmittal 2351, Change Request 7529, dated November 18, 2011
CMS JSM 08411, dated July 16, 2008
TDL-12245, dated February 23, 2012
Transmittal 2457, Change Request 7785, dated April 27, 2012
Transmittal 2622, Change Request 8005, dated December 21, 2012
Transmittal 2809, Change Request 8482, dated November 6, 2013
Transmittal 179, Change Request 8458, dated January 14, 2014
Transmittal 1755, Change Request 9861, dated November 18, 2016
Transmittal 3924, Change Request 10303, dated November 16, 2017
Transmittal 1975, Change Request 10318, dated November 9, 2017
Bipartisan Budget Act Section 50202

**Coverage Guidance**

**Coverage Indications, Limitations, and/or Medical Necessity**

NOTE: Notations are made throughout this LCD on where to find additional information and complete discussions on the topics outlined in this LCD. Providers should refer to these manuals for additional information not discussed in this LCD.

*Definitions (Note for a complete list of definitions that are applicable to this LCD, refer to Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220, A.)*

**ACTIVE PARTICIPATION** of the clinician in treatment means that the clinician personally furnishes in its entirety at least one billable service on at least one day of treatment.

**ASSESSMENT** is separate from evaluation and is included in services or procedures (it is not separately reimbursable).

**CERTIFICATION** is the physician's/nonphysician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.
INTERVAL of certified treatment (certification interval) consists of 90 calendar days or less, based on an individual's need. A physician/NPP may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report period.

TREATMENT DAY means a single calendar day on which treatment, evaluation and/or re-evaluation is provided. There could be multiple visits, treatment sessions/encounters on a treatment day.

General Therapy Guidelines

For requirements on furnishing therapy service in a pool, please refer to Pub 100-02, Chapter 15, Section 220C for a complete discussion on renting/leasing pool space, use of the rented/leased space, and documentation required to support these requirements.

Therapy services must relate directly and specifically to a written treatment plan. The plan (also known as a plan of care or plan of treatment), must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated).

The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the plan, which is described below, is not the same as certifying the plan, which is described in §220.1.1 through 220.1.3.

Outpatient therapy services shall be furnished under a plan established by:

- A physician/NPP (consultation with the treating physical therapist, occupational therapist, or speech-language pathologist is recommended. Only a physician may establish a plan of care in a CORF);
- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or
- The speech-language pathologist who will provide the speech-language pathology services.

It is acceptable to treat under two separate plans of care when different physician's/NPPs refer a patient for different conditions. It is also acceptable to combine the plans of care into one plan covering both conditions if one or the other referring physician/NPP is willing to certify the plan for both conditions. The treatment notes continue to require timed code treatment minutes and total treatment time and need not be separated by plan. Progress Reports should be combined if it is possible to make clear that the goals for each plan are addressed. Separate progress reports referencing each plan of care may also be written, at the discretion of the treating clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.

Covered therapy services must:

- Qualify as skilled therapy services;
- Be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition;
- Be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a qualified therapist; and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

Therefore, therapy services are covered when they are rendered:

- under a written treatment plan developed by the individual's physician, non-physician practitioners, optometrist, and/or therapist;
- to address specific therapeutic goals for which modalities and procedures are planned out specifically in terms of type, frequency and duration; and
- the patient's functional limitations are documented in terms that are objective and measurable.

Rehabilitative Therapy

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and
assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive objective measurements whenever possible (see objective measurement and other instruments for evaluation in the 220.3.C of this chapter). If an individual’s expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. (See definition of therapist in section 220.A of this chapter.) Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services.

Rehabilitative therapy may be needed, and improvement in a patient’s condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient’s condition or to maximize his/her functional abilities. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient’s condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel.

**Maintenance Programs**

Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

Coverage for skilled therapy services related to a reasonable and necessary maintenance program is available in the following circumstances:

- **Establishment or design of maintenance programs.** If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.

- **Delivery of maintenance programs.** Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary’s need for skilled care. A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided. However, skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program. Such skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the therapy procedures required to maintain the patient’s current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or (b) the particular patient’s special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient’s current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures. Unlike coverage for rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient’s potential for improvement from the therapy.

The deciding factors are always whether the services are considered reasonable, effective treatments for the patient’s condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel or caregivers.

Periodic evaluations of the patient’s condition and response to treatment may be covered when medically necessary if the judgment and skills of a professional provider are required.

- The design of a maintenance regimen required to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease may be considered medically necessary.
• Limited services may be considered medically necessary to establish and assist the patient and/or his caregiver with the implementation of a rehabilitation maintenance program.*

• Training of a nursing home staff to implement specific physical care needs of a patient may be covered on a very limited basis when the needs of the patient are above and beyond what would be considered normal nursing care.

• The infrequent reevaluations required to assess the patient's condition and adjust the program may be considered medically necessary.

*Note: Additional sessions at the end of a course of physical therapy designed to teach the patient or caregiver a home program or to transition the patient to home therapy are not considered to be medically necessary. It is expected that this type of training is carried out during the normal course of therapy.

It is not medically necessary for a therapist to perform or supervise maintenance programs that do not require the professional skills of a therapist. These situations include:

• services related to activities for the general good and welfare of patients (i.e., general exercises to promote overall fitness and flexibility);

• repetitive exercises to maintain gait or maintain strength and endurance, and assisted walking, such as that provided in support for feeble and unstable patients; and

• range of motion and passive exercises that are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities that can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel.

The above referenced indications do not apply to Cardiac Rehabilitation. This program requires individual plans of care and involves procedures and modalities which target a different set of clinical conditions than does physical therapy.

General Physical Therapy Guidelines (Pub. 100-02, Chapter 15, Section 230.1)

Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. For descriptions of aquatic therapy in a community pool see Pub. 100-02, Chapter 15, Section 220C.

The new personnel qualifications for physical therapists were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

A complete outline of PT and PTA qualifications for Medicare are located in Pub 100-02, Chapter 15, Section 230.1 A-D.

General Occupational Therapy Guidelines

Occupational therapy services are those services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status.

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve:

• The evaluation and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;

• The selection and teaching of task-oriented therapeutic activities designed to restore physical function;

• The planning, implementing and supervising of individualized therapeutic activity programs as part of an over all "active treatment" program for a patient with a diagnosed psychiatric illness;

The planning and implementing of therapeutic tasks and activities to restore sensory integrative function:

• The teaching of compensatory technique to improve the level of independence in the activities of daily living or adapt to an evolving deterioration in health and function, for example:

  ◦ teaching a patient who has lost the use of an arm how to pare potatoes and chop
vegetables with one hand;
• teaching an upper extremity amputee how to functionally utilize a prosthesis;
• teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities as independently as possible; or
• Teaching a patient with a hip fracture/hip replacement techniques of standing tolerance and balance to enable the patient to perform such functional activities as dressing and homemaking tasks.

• The designing, fabricating and fitting of orthotics and self-help devices; e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed independently; or
• Vocational and prevocational assessment and training, subject to the limitations specified in section 230.1B of Pub 100-02, Chapter 15.

Only a qualified occupational therapist has the knowledge, training and experience required to evaluate and, as necessary, reevaluate a patient’s level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and where appropriate, recommend to the physician/NPP a plan of treatment where appropriate.

The new personnel qualifications for occupational therapists were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

A complete outline of OT and OTA qualifications for Medicare are located in Pub 100-02, Chapter 15, Section 230.2 B-D

Occupational therapy may be required for a patient with a specific diagnosed psychiatric illness where such services are required and may be covered if coverage criteria are met.

Occupational therapy may include vocational and prevocational assessment and training.

Occupational therapy may include treatment of functional limitations that would include those therapies which restore the patient's ability to perform activities of daily living, e.g., eating, drinking, dressing, bathing, grooming, toileting, and performing personal hygiene.

General Speech-language Therapy Guidelines
Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See Pub. 100-03, Chapter 1, Section 170.3, for additional information).

See Pub 100-02, Chapter 15, Section 230.3B for requirements and definition for a qualified speech-language pathologist for Medicare coverage.

Services of speech-language pathology assistants are not recognized for Medicare coverage. Services provided by speech-language pathology assistants, even if they are licensed to provide services in their states, will be considered unskilled services and denied as not reasonable and necessary if they are billed as therapy services.
Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although and aide may help a therapist by providing unskilled services, those services are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

Evaluation Services for speech-language pathology
Speech-language pathology evaluation services are covered if they are reasonable and necessary and not excluded as routine screening by section 1862 (a)(7) of the Act. The speech-language pathologist employs a variety of formal and informal speech, language and dysphagia assessment tests to ascertain the type, causal factor(s), and severity of the speech and language or swallowing disorders. Reevaluation of patients for whom speech, language and swallowing were previously contraindicated is covered only if the patient exhibits a change in medical condition. However, monthly reevaluations; e.g., a Western Aphasia Battery, for a patient undergoing a rehabilitative speech-language pathology program, are considered a part of the treatment session and shall not be covered as a separate evaluation for billing purposes. Although hearing screening by the speech-language pathologist may be part of an evaluation, it is not billable as separate service.
**Therapeutic Services**

The following are examples of common medical disorders and resulting communication deficits, which may necessitate active rehabilitative therapy. This list is not all-inclusive:

- Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia dysphasia, apraxia, and dysarthria;
- Neurological disease such as Parkinsonism or Multiple Sclerosis with dysarthria, dysphagia, inadequate respiratory volume control, or voice disorder; or
- Laryngeal carcinoma requiring laryngectomy resulting in aphony.

**Impairments of the Auditory System**

The terms aural rehabilitation, auditory rehabilitation, auditory processing, lipreading and speechreading are among the terms used to describe covered services related to perception and comprehension of sound through the auditory system. See Pub 100-04, chapter 12, section 30.3 for billing instructions. For example:

- Auditory processing evaluation and treatment may be covered and medically necessary. Examples include but are not limited to services for certain neurological impairments or the absence of natural auditory stimulation that results in impaired ability to process sound. Certain auditory processing disorders require diagnostic audiological tests in addition to speech-language pathology evaluation and treatment.
- Evaluation and treatment for disorders of the auditory system may be covered and medically necessary, for example, when it has been determined by a speech language pathologist in collaboration with an audiologist that the hearing impaired beneficiary’s current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient’s functional communications needs. Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologist may provide treatment.

Assessment for the need for rehabilitation of the auditory system (but not the vestibular system) may be done by a speech language pathologist. Examples include but are not limited to: evaluation of comprehension and production of language in oral, signed or written modalities, speech and voice production, listening skills, speech reading, communications strategies, and the impact of the hearing loss on the patient/client and family.

Examples of rehabilitation include but are not limited to treatment that focuses on comprehension, and production of language in oral, signed or written modalities: speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training, communication strategies, education and counseling. In determining the necessity for treatment, the beneficiary's performance in both clinical and natural environment should be considered.

**Dysphagia**

Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death. It is most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment.

The speech-language pathologist performs clinical and instrumental assessments and analyzes and integrates the diagnostic information to determine candidacy for intervention as well as appropriate compensations and rehabilitative therapy techniques. The equipment that is used in the examination may be fixed, mobile or portable. Professional guidelines recommend that the service be provided in a team setting with a physician/NPP who provides supervision of the radiological examination and interpretation of medical conditions revealed in it.

Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it related to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques.
Specific Procedure and Modality Guidelines for Physical and/or Occupational Therapy

**Evaluation Codes (CPT Codes 97161, 97162, 97163, and 97164 for physical therapy and (CPT Codes 97165, 97166, 97167, and 97168 for occupational therapy)**

The initial evaluation identifies the problem or difficulty the patient is having which helps determine the appropriate therapy necessary to treat the patient. An evaluation is a comprehensive service requiring professional skills to make clinical judgments about conditions for which services are indicated. If a new diagnosis/problem is encountered, then an additional evaluation may be appropriate to determine what course of treatment is necessary for the separate identifiable diagnosis/problem.

Re-evaluations are indicated periodically when the professional assessment indicates a significant improvement or decline in the patient's condition or functional status. The re-evaluation focuses on the patient's progress toward current goals. Professional judgment is used to determine continued care, modifying goals and/or treatment or terminating services.

**Traction/Mechanical Modality (CPT code 97012)**

Traction is generally used for joints, especially of the lumbar or cervical spine, with the expectation of relieving pain in or originating from those areas, or increasing the range of motion of the joint. Specific indications for the use of mechanical traction include, but are not limited to, neck and back disorders such as disc herniation, lumbago, cervicalgia, sciatica, cervical and lumbar radiculopathy. This modality is generally used in conjunction with therapeutic procedures and not as an isolated treatment.

**Vasopneumatic Devices (CPT code 97016)**

The use of vasopneumatic devices may be considered medically necessary for the application of pressure to an extremity for the purpose of reducing edema.

Specific indications for the use of vasopneumatic devices include:

- reduction of edema after acute injury;
- lymphedema of an extremity; and/or
- education on the use of a lymphedema pump for home use.

Note: Further treatment of lymphedema by a provider after the educational visits are generally not medically necessary.

Education on the use of a lymphedema pump for home use can typically be completed in no more than three (3) visits.

The use of vasopneumatic devices would not be covered as a temporary treatment while awaiting receipt of ordered Jobst stockings.

**Paraffin Bath (CPT code 97018)**

Paraffin bath, also known as hot wax treatment, is primarily used for pain relief in chronic joint problems of the wrists, hands, and feet.

Specific indications for the use of paraffin baths include:

- the patient has a contracture as a result of rheumatoid arthritis;
- the patient has a contracture as a result of scleroderma;
- the patient has acute synovitis;
- the patient has post-traumatic conditions;
- the patient has hypertrophic scarring;
- the patient has degenerative joint disease;
- the patient has osteoarthritis;
- the patient has post-surgical conditions or tendon repairs, or;
- the patient is status post sprains or strains.

**Whirlpool (CPT code 97022)/Hubbard Tank (CPT code 97036)**

Whirlpool bath and Hubbard tanks are the most common forms of hydrotherapy. The use of sterile whirlpool is considered medically necessary when used as part of a plan directed at facilitating the healing of an open wound (e.g., burns).
Specific indications for the use of sterile whirlpools include:

- the patient has a documented open wound which is draining, has a foul odor, or evidence of necrotic tissue; and/or
- the patient has a documented need for wound debridement/bandage removal.

General whirlpool therapies (CPT code 97022)/Hubbard tank (CPT code 97036) are considered medically necessary when used to enhance the patient's ability to perform therapeutic exercise.

Specific indications for the use of general whirlpool therapies include:

- the patient who suffers from generalized weakness in addition to a specific functional limitation, and requires the buoyancy provided in the whirlpool in order to perform the therapeutic exercise, and/or
- the patient who requires joint stretching (joint range of motion) prior to exercise on dry land.

Fluidized Therapy for Dry Heat (CPT code 97022)

Fluidized therapy is a high intensity heat modality consisting of a dry whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having properties of a liquid. Use of fluidized therapy dry heat is covered as an acceptable alternative to other heat therapy modalities in the treatment of acute or subacute traumatic or nontraumatic musculoskeletal disorders of the extremities.

Diathermy (CPT code 97024)

Short wave diathermy is an effective modality for heating skeletal muscle. Because heating is accomplished without physical contact between the modality and the skin, it can be used even if skin is abraded, as long as there is no significant edema. The use of diathermy is considered medically necessary for the delivery of heat to deep tissues such as skeletal muscle and joints for the reduction of pain, joint stiffness, and muscle spasms.

Specific indications for the use of diathermy include:

- the patient has osteoarthritis, rheumatoid arthritis, or traumatic arthritis;
- the patient has sustained a strain or sprain;
- the patient has acute or chronic bursitis;
- the patient has sustained a traumatic injury to muscle, ligament, or tendon resulting in functional loss;
- the patient has a joint dislocation or subluxation;
- the patient requires treatment for a post surgical functional loss;
- the patient has an adhesive capsulitis; and/or
- the patient has a joint contracture.

Diathermy is not considered medically necessary for the treatment of asthma, bronchitis, or any other pulmonary condition. Please refer to the ICD-10 Codes that Do Not Support Medical Necessity Section of the policy.

Diathermy/Diapulse (CPT code 97024)

High energy pulsed wave diathermy machines have been determined to produce the same therapeutic benefit as standard diathermy; therefore, any reimbursement for diathermy will be made at the same level as standard diathermy.

Diathermy/Microwave (CPT code 97024)

Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of this modality, this service will be denied as not reasonable and necessary.

Infrared Application (CPT code 97026)

Based on CR 9861 (Coding Revisions to NCDs), CMS has instructed contractors to remove all associated diagnosis codes in current editing for CPT code 97026 (Application of a modality to 1 or more areas;
infrared) effective 10/01/15 as infrared therapy is noncovered for all indications. Therefore, CPT code 97026 is noncovered.

**Ultraviolet Therapy (CPT code 97028)**

Photons in the ultraviolet (UV) spectrum are more energetic than those in the visible or infrared regions. Their interaction with tissue and bacteria can produce nonthermal photochemical reactions, the effects of which provide the rationale for ultraviolet treatment. Ultraviolet light is highly bacteriocidal to motile bacteria, and it increases vascularization at the margins of the wounds.

The application of ultraviolet therapy is considered medically necessary for the patient requiring the application of a drying heat. The specific indications for this therapy are:

- A patient having an open wound. Minimal erythema dosage must be documented.
- Severe psoriasis limiting range of motion.

**Electrical Stimulation (Manual) (CPT code 97032)**

This modality includes the following types of electrical stimulation:

- Transcutaneous electrical nerve stimulation which produces analgesia, strengthening, and functional electrical stimulation. The use of electrical stimulation is considered medically necessary to reduce pain and/or edema and achieve muscular contraction during exercise.
- High voltage pulsed current, also called electrogalvanic stimulation, which may be useful for the reduction of swelling and the control of pain.
- Neuro-muscular stimulation which is used for retraining weak muscles following surgery or injury and is taken to the point of visible muscle contraction.
- Interferential current/medium current units, which use a frequency that allows the current to go deeper. IFC is used to control swelling and pain.

Specific indications for the use of electrical stimulation include:

- the patient has documented dependent peripheral edema with an accompanying reduction in the ability to contract muscles;
- the patient has a documented reduction in the ability to contract muscles or in the strength of the muscle contraction;
- the patient has a condition that requires an educational program for self-stimulation of denervated muscle (educational program should be limited to 5-7 sessions);
- the patient has a condition that requires muscle re-education involving a training program (e.g., functional electrical stimulation);
- the patient has a painful condition that requires analgesia or a muscle spasm that requires reduction prior to an exercise program; or
- the patient is undergoing treatment for disuse atrophy using a specific type of neurostimulator (NMES) which transmits an electrical impulse to the skin over selected muscle groups by way of electrodes. 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).

Standard treatment is 3 to 4 sessions a week for one month when used as adjunctive therapy or for muscle retraining. Additional sessions must meet medical necessity requirements.

**Electrical stimulation used in the treatment of facial nerve paralysis, commonly known as Bell’s Palsy, is not covered under Medicare because its clinical effectiveness has not been established.** Please refer to the ICD-10 Codes that Do Not Support Medical Necessity section.

While electric nerve stimulation has been employed to control chronic intractable pain for some time, its use in the treatment of motor function disorders, such as multiple sclerosis, is a recent innovation, and the medical effectiveness of such therapy has not been verified by scientifically controlled studies. Therefore, where electric nerve stimulation is employed to treat motor function disorders, no reimbursement may be made for the stimulator or for the services related to its implantation since this treatment cannot be considered reasonable and necessary.

**Electrical stimulation should not be reported for wound care of any sort because wound care does not require constant attendance.**

See Electrical Stimulation for Indications Other Than Wound Care (G0283) for pelvic floor electrical
stimulators.

**Iontophoresis Application (CPT code 97033)**

Iontophoresis is a process in which electrically charged molecules or atoms (e.g., ions) are driven into tissue with an electric field. Voltage provides the driving force. Parameters such as drug polarity and electrophoretic mobility must be known in order to be able to assess whether iontophoresis can deliver therapeutic concentrations of a medication at sites in or below the skin.

The application of iontophoresis is considered medically necessary for the topical delivery of medications into a specific area of the body. The medication and dosage information may be recorded in the plan of treatment or maintained on a separate prescription signed by the health care provider responsible for certifying the plan of treatment.

Specific indications for the use of iontophoresis application include:

- the patient has tendonitis or calcific tendonitis;
- the patient has bursitis; or
- the patient has adhesive capsulitis.

**Contrast Baths (CPT code 97034)**

Contrast baths are a special form of therapeutic heat and cold that can be applied to distal extremities. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold. Although a variety of applications are possible, contrast baths often are used in treatment programs for rheumatoid arthritis and reflex sympathetic dystrophy.

The use of contrast baths is considered medically necessary to desensitize patients to pain by reflex hyperemia produced by the alternating exposure to heat and cold.

Specific indications for the use of contrast baths include:

- the patient has rheumatoid arthritis or other inflammatory arthritis;
- the patient has reflex sympathetic dystrophy; or
- the patient has a sprain or strain resulting from an acute injury.

**Ultrasound Application (CPT code 97035)**

Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 Mhz. In the human body ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone can receive an even greater dosage of ultrasound, as much as 30% more. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where they receive a more intense irradiation, it is an ideal modality for increasing mobility in those tissues with restricted range of motion.

The application of ultrasound is considered medically necessary for patients requiring deep heat to a specific area for reduction of pain, spasm, and joint stiffness, and the increase of muscle, tendon and ligament flexibility.

Specific indications for the use of Ultrasound Application include:

- the patient has tightened structures limiting joint motion that require an increase in extensibility; or
- the patient has symptomatic soft tissue calcification.

Ultrasound Application is not considered to be medically necessary for the treatment of asthma, bronchitis, or any other pulmonary condition. Please see ICD-10 Codes That Do Not Support Medical Necessity section of the policy.

Standard treatment is 3-4 treatments per week for one month. Additional treatments must meet medical necessity requirements.

**Hubbard Tank (CPT code 97036):**

Please refer to procedure code 97022 for clinical guidelines for procedure code 97036.

**Therapeutic Exercise (CPT code 97110)**
Therapeutic exercise is performed on dry land with a patient either actively, active-assisted, or passively participating (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening).

Therapeutic exercise is considered medically necessary if at least one of the following conditions is present and documented:

- the patient having weakness, contracture, stiffness secondary to spasm, spasticity, decreased range of motion, gait problem, balance and/or coordination deficits, abnormal posture, muscle imbalance, or
- the patient needing to improve mobility, stretching, strengthening, coordination, control of extremities, dexterity, range of motion, or endurance as part of activities of daily living training, or re-education.

**Neuromuscular Reeducation (CPT code 97112)**

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation, Feldenkreis, Bobath, BAP's boards, and desensitization techniques).

Neuromuscular reeducation may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has the loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
- the patient has nerve palsy, such as peroneal nerve injury causing foot drop; or
- the patient has muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease, or having had a spinal cord disease or trauma.

**Aquatic Therapy with Therapeutic Exercise (CPT code 97113)**

This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). Hydrotherapy is useful in post-operative extremity (joint) rehabilitation (e.g., total hip or knee arthroplasty, total shoulder, elbow, wrist arthroplasty).

Aquatic therapy with therapeutic exercise may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has rheumatoid arthritis;
- the patient has had a cast removed and requiring mobilization of limbs;
- the patient has paralysis or hemiparesis;
- the patient has had a recent amputation;
- the patient is recovering from a paralytic condition;
- the patient requires limb mobilization after a head trauma; or
- the patient is unable to tolerate exercise for rehabilitation under gravity based weight bearing.

**Gait Training (CPT code 97116)**

This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

Specific indications for gait training include:

- the patient has suffered a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation;
- the patient has recently suffered a musculoskeletal trauma, either due to an accident or surgery, requiring ambulation education;
- the patient has a chronic, progressively debilitating condition for which safe ambulation has recently become a concern;
- the patient has had an injury or condition that requires instruction in the use of a walker, crutches, or cane;
- the patient has been fitted with a brace prosthesis and requiring instruction in ambulation; and/or
- the patient has a condition that requires retraining in stairs/steps or chair transfer in addition to general ambulation.

**Neuromuscular Electrical Stimulation (NMES) (CPT code 97116)**
Coverage of NMES to treat muscle atrophy is limited to the treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). (See 160.13 for an explanation of coverage of medically necessary supplies for the effective use of NMES.) Use for Walking in Patients with Spinal Cord Injury (SCI).

The type of NMES that is used to enhance the ability to walk of SCI patients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. Coverage for the use of NMES/FES is limited to SCI patients for walking, who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months. The trial period of physical therapy will enable the physician treating the patient for his or her spinal cord injury to properly evaluate the person's ability to use these devices frequently and for the long term. Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program.

The goal of physical therapy must be to train SCI patients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy. Coverage for NMES/FES for walking will be covered in SCI patients with all of the following characteristics:

1. Persons with intact lower motor unite (L1 and below) (both muscle and peripheral nerve);
2. Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;
3. Persons that demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction;
4. Persons that possess high motivation, commitment and cognitive ability to use such devices for walking;
5. Persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;
6. Persons that can demonstrate hand and finger function to manipulate controls;
7. Persons with at least 6-month post recovery spinal cord injury and restorative surgery;
8. Persons with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
9. Persons who have demonstrated a willingness to use the device long-term.

NMES/FES for walking will not be covered in SCI patient with any of the following:

1. Persons with cardiac pacemakers;
2. Severe scoliosis or severe osteoporosis;
3. Skin disease or cancer at area of stimulation;
4. Irreversible contracture; or
5. Autonomic dyslexia.

The only settings where therapists with the sufficient skills to provide these services are employed, are inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of a one-on-one training program.

Additional therapy after the purchase of the DME would be limited by our general policies in converge of skilled physical therapy.

**Therapeutic Massage Therapy (CPT code 97124)**

Massage is the application of systemic manipulation to the soft tissues of the body for therapeutic purposes. Although various assistive devices and electrical equipment are available for the purpose of delivering massage, use of the hands is considered the most effective method of application, because palpation can be used as an assessment as well as a treatment tool.

Massage therapy, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion) may be considered medically necessary if at least one of the following conditions is present and documented:

- the patient has paralyzed musculature contributing to impaired circulation;
- the patient has excessive fluids in interstitial spaces or joints;
- the patient has sensitivity of tissues to pressure;
- the patient has tight muscles resulting in shortening and/or spasticity of affective muscles;
- the patient has abnormal adherence of tissue to surrounding tissue;
- the patient requires relaxation in preparation for neuromuscular re-education or therapeutic exercise; or
the patient has contractures and decreased range of motion.

**Manual Therapy (CPT code 97140):**

Manual therapy includes the following modalities:

- Manual traction may be considered reasonable and necessary for cervical radiculopathy.
- Joint mobilization (peripheral or spinal) may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.
- Myofascial release/soft tissue mobilization, one or more regions, may be medically necessary for treatment of restricted motion of soft tissues involved in extremities, neck, and trunk. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, or stretching of shortened muscular or connective tissue. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.
- Manipulation may be medically necessary for treatment of painful spasm or restricted motion of soft tissues. It may also be used as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.

**Therapeutic procedure(s), group (2 or more individuals) (CPT Code 97150)**

Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individual can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required. If a therapist or physician performs any of the procedures with two or more individuals concurrently or during the same time period, then only 97150 is reported for each patient.

**Therapeutic Activities (CPT code 97530)**

Therapeutic activities are considered medically necessary for patients needing a broad range of rehabilitative techniques that involve movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the professional skills of a therapist and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and be directed at a specific outcome.

In order for therapeutic activities to be covered, the following requirements must be met:

- the patient's condition is such that he/she is unable to perform therapeutic activities except under the direct supervision of a physician or physical therapist; and
- there is a clear correlation between the type of exercise performed and the patient's underlying medical condition for which the therapeutic activities were prescribed.

**Other Therapeutic Procedures (HCPCS/CPT codes G0515 and 97533):**

Development of cognitive skills to improve attention, memory or problem solving, may be medically necessary for patients having neurologic conditions such as head injury or trauma, stroke, muscular dystrophy and/or multiple sclerosis or other neurological diseases. Reassessment of the patient's progress should occur every 2-3 months showing significant and measurable improvement. These procedures may be medically necessary when included in a patient's individual treatment plan aimed at improving or restoring specific functions which were impaired by an identified illness or injury and when the improved functional physical/cognitive abilities of the patient that are expected to be achieved are specified in the plan. If at anytime during the treatment period it becomes obvious that continued cognitive rehabilitation is not likely to be effective, that the service is no longer needed, or that all realistic attainable goals have been met then the treatment should be discontinued. The patient must have the capacity to learn from instructions.

**Self-Care/Home Management Training (CPT Code 97535)**

This procedure is medically necessary only when it requires the professional skills of a therapist, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific outcome.
The patient must have the capacity to learn from instructions.

Services provided concurrently by physicians, optometrists, physical therapists, and occupational therapists may be covered if separate and distinct goals are documented in the treatment plans.

**Community/Work Reintegration Training (CPT Code 97537)**

Community reintegration is performed in conjunction with other therapeutic procedures such as gait training and self-care/home management training. The payment for community reintegration training is bundled into the payment for those other services. Therefore, these services are not separately reimbursable.

Services which are related solely to specific employment opportunities, work skills, or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by section 1862(a)(1) of the Social Security Act.

**Wheelchair Management (eg, assessment, fitting, training), (CPT Code 97542)**

An assessment may be done to evaluate the patient's need for a wheelchair. This may include the patient's strength, living situation, weight, skin integrity, etc. Once the patient's needs are established, measurements are taken prior to ordering the equipment.

For assessment and fitting, the patient's abilities are observed, maneuverability skills are practiced and instructions are provided for adjustments to the wheelchair and wheelchair use.

Usually, the assessment(s) and fitting can be completed in 1-2 sessions. Medical necessity must support additional sessions.

Wheelchair management also trains the patient in functional activities that promote optimal safety, mobility and transfers. Patients who are wheelchair bound may occasionally need skilled input on positioning to avoid pressure points, contractures, and other medical complications.

This procedure is medically necessary only when it requires the professional skills of a therapist, is designed to address specific needs of the patient, and may be part of an active treatment plan directed at a specific goal.

The patient must have the capacity to learn from instructions.

Typically 3-4 total sessions should be sufficient to teach the patient these skills. Medical necessity must support additional sessions.

**Work Hardening/Conditioning (CPT Codes 97545-97546)**

This service is not covered. These services are related solely to specific work skills, and they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are not covered.

**Physical Performance Test or Measurement (CPT code 97750)**

A physical performance test or measurement may be reasonable and necessary for patients with neurological or musculoskeletal conditions when there is a need to evaluate the ability to perform specific tasks. It may include a number of multi-varied tests and measurements of physical performance of a select area or number of areas.

These services are not to be used in lieu of evaluation or re-evaluation services. It would not be appropriate to report a code from the 95831-95834 or the 95851-95852 series in addition to 97750. It is not medically reasonable and necessary to bill this service as part of a routine assessment/evaluation of rehabilitation services (97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168). Direct one-on-one patient contact is required.

**Assistive Technology Assessment (CPT code 97755)**

This procedure is used by the provider to assess for the suitability and benefits of technological interface that will help restore, augment, or compensate for existing functional ability in the patient.

The patient's voluntary motions (e.g., oral motor strength, head/neck range of motion and strength, ocular motor control, quality of voice output and client's ability to use the accessibility components and systems) are identified and assessed. Multiple systems/components are tested to determine optimal interface between client and technology applications.
Appropriateness of commercial (off-the-shelf) components/systems is determined. The need for modification of commercial components/systems is assessed. Custom components/systems are designed and tested as needed for the patient.

Coverage is specifically for assessment of mobility and seating systems that require high level adaptation, not for routine seating and mobility systems (e.g., manual/power wheelchair evaluations).

Utilization of this service should be infrequent.

**Orthotic Management (CPT code 97760):**
Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies), and/or trunk, may be considered reasonable and necessary if there is an indication for education for the application of orthotics and the functional use of orthotics is present and documented in the patient's medical records maintained by the provider.

Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk reflects the fitting as well as the training, as the training in the use of the orthotic is done at the time of the fitting. Typically, orthotic training can be completed in three (3) visits, but based on patient condition/status, may require additional visits. In addition, subsequent visits may be necessary for re-evaluation in modification of the orthotic and/or program. Additional training must meet medical necessity requirements.

**Prosthetic Training (CPT code 97761)**
Prosthetic(s) training may be considered reasonable and medically necessary if there is a documented indication for education for the application and functional use of the prosthetic in the patient's medical records maintained by the provider.

Periodic revisits beyond the third month must meet medical necessity requirements.

One would not expect to see more than 30 minutes of prosthetic training billed on a given date. Additional training must meet medical necessity requirements.

**Checkout for Orthotic/Prosthetic Use, Established Patient (CPT Code 97763)**
These assessments are medically necessary when a device is newly issued or when there is a modification or re-issue of the orthotic/prosthetic device.

These assessments may also be medically necessary when patients experience a loss of function directly related to the device (e.g., pain, skin breakdown, or falls).

These assessments are not medically necessary when a device is replaced after normal wear.

**Electrical Stimulation for the Treatment of Wounds (CPT Codes G0281-G0282)**
For services performed on or after April 1, 2003, Medicare will cover electrical stimulation for the treatment of wounds only for chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers, venous stasis ulcers, and non-pressure chronic ulcers (G0281). All other uses of electrical stimulation for the treatment of wounds (G0282) are not covered by Medicare. Electrical stimulation will not be covered as an initial treatment modality. The use of electrical stimulation will only be covered after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electrical stimulation is being used, wounds must be evaluated periodically by the treating physician or non-physician practitioner, but no less than every 30 days by a physician. Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electrical stimulation must be discontinued when the wound demonstrates a 100 percent epithelialized wound bed.

**Electrical Stimulation for Indications Other Than Wound Care (CPT code G0283)**
Electrical stimulation for indications other than wound care is considered medically necessary when performed as an integral part of the therapy plan of care.

*Pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to*
increase periurethral muscle strength.

This modality does not require direct (one-on-one) patient contact by the provider.

Medicare considers the following indications noncovered:

Electrotherapy for the treatment of facial nerve paralysis, commonly known as Bell’s Palsy, is not covered under Medicare because its clinical effectiveness has not been established.

While electric nerve stimulation has been employed to control chronic intractable pain for some time, its use in the treatment of motor function disorders, such as multiple sclerosis, is a recent innovation, and the medical effectiveness of such therapy has not been verified by scientifically controlled studies. Therefore, where electric nerve stimulation is employed to treat motor function disorders, no reimbursement may be made for the stimulator or for the services related to its implantation since this treatment cannot be considered reasonable and necessary.

Please refer to procedure code 97032 for additional clinical guidelines for electrical stimulation.

Specific Complex Decongestive Physiotherapy Guidelines:

Complex decongestive physiotherapy (CDP) consists of skin care, manual lymph drainage, compression wrapping, and exercises. Although there is no means to allow payment of the total treatment via one treatment code, payment will be allowed for the therapy services associated with the treatment (i.e., 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168). Other services such as skin care and the supplies associated with the compression wrapping are included in the therapy services performed during each session.

The goal of this therapy is not to achieve maximum volume reduction, but to ultimately transfer the responsibility of the care from the clinic, hospital, or doctor, to home care by the patient, patient's family or patient's caregiver. Unless the patient is able to continue therapy at home, there is only temporary benefit from the treatment. The endpoint of treatment is not when the edema resolves or stabilizes, but when the patient and/or their cohort are able to continue the treatments at home. Patients who do not have the capacity or support system to accomplish these skills in a reasonable time are not good candidates for CDP.

It is expected that therapy education sessions would usually last for 1 to 2 weeks, with the patient attending 3-5 times per week, depending on the progress of the therapy. After that time, there should have been enough teaching and instruction that the care could be continued by the patient or patient caregiver in the home setting. The maximum benefits of treatment are not expected unless the patient continues treatment at home.

The therapy billed in conjunction with the manual lymph drainage therapy will be subject to all national and local policies for therapy services.

The coverage of the CDP therapy would only be allowed if all of the following conditions have been met:

- There is a physician documented diagnosis of lymphedema; and the physician specifically orders CDP.
- The patient is symptomatic for lymphedema, with limitation of function related to self care, mobility and/or safety.
- The patient or patient caregiver has the ability to understand and comply with home care continuation of treatment regimen.
- The services are being performed by a health care professional who has received specialized training in this form of treatment.

Currently, services for lymphedema are covered by the lymphedema pump. Some providers are proposing noninvasive complex lymphedema therapy as an alternative to pumps. A patient requiring both modes of treatment should be rare. In addition, it is not expected that PT and OT would be performed concurrently; (i.e., both PT and OT providing the therapeutic exercise portion of the session).

The therapy services for CDP must be provided either by or under the direct personal supervision of the physician or independently practicing therapist.

Summary of Evidence
Analysis of Evidence
(Rationale for Determination)

N/A

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

012x  Hospital Inpatient (Medicare Part B only)
013x  Hospital Outpatient
021x  Skilled Nursing - Inpatient (Including Medicare Part A)
022x  Skilled Nursing - Inpatient (Medicare Part B only)
023x  Skilled Nursing - Outpatient
071x  Clinic - Rural Health
074x  Clinic - Outpatient Rehabilitation Facility (ORF)
075x  Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
077x  Clinic - Federally Qualified Health Center (FQHC)
085x  Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

042X  Physical Therapy - General Classification
043X  Occupational Therapy - General Classification
044X  Speech-Language Pathology - General Classification

CPT/HCPCS Codes

Group 1 Paragraph:
The following codes are specific to speech-language therapy services:

Group 1 Codes:

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<tr>
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<tr>
<td>96111</td>
<td>DEVELOPMENTAL TESTING, (INCLUDES ASSESSMENT OF MOTOR, LANGUAGE, SOCIAL, ADAPTIVE, AND/OR COGNITIVE FUNCTIONING BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS) WITH INTERPRETATION AND REPORT</td>
</tr>
<tr>
<td>96116</td>
<td>NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, LANGUAGE, MEMORY, PLANNING AND PROBLEM SOLVING, AND VISUAL SPATIAL ABILITIES), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT</td>
</tr>
<tr>
<td>96125</td>
<td>STANDARDIZED COGNITIVE PERFORMANCE TESTING (EG, ROSS INFORMATION PROCESSING ASSESSMENT) PER HOUR OF A QUALIFIED HEALTH CARE PROFESSIONAL'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT</td>
</tr>
<tr>
<td>G0515</td>
<td>DEVELOPMENT OF COGNITIVE SKILLS TO IMPROVE ATTENTION, MEMORY, PROBLEM SOLVING (INCLUDES COMPENSATORY TRAINING), DIRECT (ONE-ON-ONE) PATIENT CONTACT, EACH 15 MINUTES</td>
</tr>
</tbody>
</table>

**Group 2 Paragraph:**

The following codes are specific to physical and/or occupational therapy services:

**Group 2 Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96125</td>
<td>STANDARDIZED COGNITIVE PERFORMANCE TESTING (EG, ROSS INFORMATION PROCESSING ASSESSMENT) PER HOUR OF A QUALIFIED HEALTH CARE PROFESSIONAL'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT</td>
</tr>
<tr>
<td>97012</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL</td>
</tr>
<tr>
<td>97016</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; VASOPNEUMATIC DEVICES</td>
</tr>
<tr>
<td>97018</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; PARAFFIN BATH</td>
</tr>
<tr>
<td>97022</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; WHIRLPOOL</td>
</tr>
<tr>
<td>97024</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (EG, MICROWAVE)</td>
</tr>
<tr>
<td>97028</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRAVIOLET</td>
</tr>
<tr>
<td>97032</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES</td>
</tr>
<tr>
<td>97033</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES</td>
</tr>
<tr>
<td>97034</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES</td>
</tr>
<tr>
<td>97035</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES</td>
</tr>
<tr>
<td>97036</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HUBBARD TANK, EACH 15 MINUTES</td>
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<td>97110</td>
<td>THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY</td>
</tr>
<tr>
<td>97112</td>
<td>THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE,</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>97113</td>
<td>THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES</td>
</tr>
<tr>
<td>97116</td>
<td>THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)</td>
</tr>
<tr>
<td>97124</td>
<td>THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)</td>
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<tr>
<td>97140</td>
<td>MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES</td>
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<tr>
<td>97150</td>
<td>THERAPEUTIC PROCEDURE(S), GROUP (2 OR MORE INDIVIDUALS)</td>
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<tr>
<td>97161</td>
<td>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.</td>
</tr>
<tr>
<td>97162</td>
<td>PHYSICAL THERAPY EVALUATION: MODERATE COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY OF PRESENT PROBLEM WITH 1-2 PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEMS USING STANDARDIZED TESTS AND MEASURES IN ADDRESSING A TOTAL OF 3 OR MORE ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; AN EVOLVING CLINICAL PRESENTATION WITH CHANGING CHARACTERISTICS; AND CLINICAL DECISION MAKING OF MODERATE COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
</tr>
<tr>
<td>97163</td>
<td>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.</td>
</tr>
<tr>
<td>97164</td>
<td>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.</td>
</tr>
<tr>
<td>97165</td>
<td>OCCUPATIONAL THERAPY EVALUATION, LOW COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY HISTORY, WHICH INCLUDES A BRIEF HISTORY INCLUDING REVIEW OF MEDICAL AND/OR THERAPY RECORDS RELATING TO THE PRESENTING PROBLEM; AN ASSESSMENT(S) THAT IDENTIFIES 1-3 PERFORMANCE DEFICITS (IE, RELATING TO PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL SKILLS) THAT RESULT IN ACTIVITY LIMITATIONS AND/OR PARTICIPATION RESTRICTIONS; AND CLINICAL DECISION MAKING OF LOW COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE OCCUPATIONAL PROFILE, ANALYSIS OF DATA FROM PROBLEM-FOCUSED ASSESSMENT(S), AND CONSIDERATION OF A LIMITED NUMBER OF TREATMENT OPTIONS. PATIENT PRESENTS WITH NO COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE. MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NOT NECESSARY TO ENABLE COMPLETION OF EVALUATION COMPONENT. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
</tr>
<tr>
<td>97166</td>
<td>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 COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE OCCUPATIONAL PROFILE, ANALYSIS OF DATA FROM PROBLEM-FOCUSED ASSESSMENT(S), AND CONSIDERATION OF A LIMITED NUMBER OF TREATMENT OPTIONS. PATIENT PRESENTS WITH NO COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE. MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NOT NECESSARY TO ENABLE COMPLETION OF EVALUATION COMPONENT. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.</td>
</tr>
</tbody>
</table>
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 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 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

97550 PHYSICAL PERFORMANCE TEST OR MEASUREMENT (E.G., MUSCULOSKELETAL, FUNCTIONAL CAPACITY), WITH WRITTEN REPORT, EACH 15 MINUTES

97555 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

97560 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

97561 PROSTHETIC(S) TRAINING, UPPER AND/OR LOWER EXTREMITY(IES), INITIAL PROSTHETIC(S) ENCOUNTER, EACH 15 MINUTES

97563 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

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 OF CARE

G0282 ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0281

G0283 ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE
**ICD-10 Codes that Support Medical Necessity**

**Group 1 Paragraph:**

**ICD-10 Codes**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX000</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**ICD-10 Codes that DO NOT Support Medical Necessity**

**Group 1 Paragraph:**

For Procedure Code 97116 when billed for NMES/FES to enhance walking for SCI patients:

Any ICD-10's for skin disease or cancer at the area of stimulation (Program Memorandum AB-02-156, Change Request 2314)

*If diagnosis codes are Z95.0, Z95.810, Z95.818, Z95.9, Z97.8, Z98.3, Z98.62, and Z98.890 are billed, the underlying disease should also be billed.

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G90.4</td>
<td>Autonomic dysreflexia</td>
</tr>
<tr>
<td>M21.00 - M21.059</td>
<td>Valgus deformity, not elsewhere classified, unspecified site - Valgus deformity, not elsewhere classified, unspecified hip</td>
</tr>
<tr>
<td>M21.071 - M21.159</td>
<td>Valgus deformity, not elsewhere classified, right ankle - Varus deformity, not elsewhere classified, unspecified</td>
</tr>
<tr>
<td>M21.171 - M21.379</td>
<td>Varus deformity, not elsewhere classified, right ankle - Foot drop, unspecified foot</td>
</tr>
<tr>
<td>M21.511 - M21.859</td>
<td>Acquired clawhand, right hand - Other specified acquired deformities of unspecified thigh</td>
</tr>
<tr>
<td>M21.90 - M21.969</td>
<td>Unspecified acquired deformity of unspecified limb - Unspecified acquired deformity of unspecified lower leg</td>
</tr>
<tr>
<td>M41.40 - M41.57</td>
<td>Neuromuscular scoliosis, site unspecified - Other secondary scoliosis, lumbosacral region</td>
</tr>
<tr>
<td>M43.00 - M43.19</td>
<td>Spondylolisthesis, multiple sites in spine - Spondylolisthesis, multiple sites in spine</td>
</tr>
<tr>
<td>M43.8X9</td>
<td>Other specified deforming dorsopathies, site unspecified</td>
</tr>
<tr>
<td>M81.0 - M81.8</td>
<td>Age-related osteoporosis without current pathological fracture - Other osteoporosis without current pathological fracture</td>
</tr>
<tr>
<td>M99.83 - M99.84</td>
<td>Other biomechanical lesions of lumbar region - Other biomechanical lesions of sacral region</td>
</tr>
<tr>
<td>Q67.5</td>
<td>Congenital deformity of spine</td>
</tr>
<tr>
<td>Q76.3</td>
<td>Congenital scoliosis due to congenital bony malformation</td>
</tr>
<tr>
<td>Q76.425 - Q76.429</td>
<td>Congenital lordosis, thoracolumbar region - Congenital lordosis, unspecified region</td>
</tr>
<tr>
<td>Z45.010 - Z45.018</td>
<td>Encounter for checking and testing of cardiac pacemaker pulse generator [battery] - Encounter for adjustment and management of other part of cardiac pacemaker</td>
</tr>
<tr>
<td>Z95.0*</td>
<td>Presence of cardiac pacemaker</td>
</tr>
<tr>
<td>Z95.810*</td>
<td>Presence of automatic (implantable) cardiac defibrillator</td>
</tr>
<tr>
<td>Z95.818*</td>
<td>Presence of other cardiac implants and grafts</td>
</tr>
<tr>
<td>Z95.9*</td>
<td>Presence of cardiac and vascular implant and graft, unspecified</td>
</tr>
<tr>
<td>Z97.8*</td>
<td>Presence of other specified devices</td>
</tr>
<tr>
<td>Z98.3*</td>
<td>Post therapeutic collapse of lung status</td>
</tr>
<tr>
<td>Z98.62*</td>
<td>Peripheral vascular angioplasty status</td>
</tr>
<tr>
<td>Z98.890*</td>
<td>Other specified postprocedural states</td>
</tr>
</tbody>
</table>

**Group 2 Paragraph:**

For Procedure Codes G0283 and 97032 (Electrical-Stimulation)
**Group 2 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G51.0</td>
<td>Bell’s palsy</td>
</tr>
</tbody>
</table>

**Group 3 Paragraph:**

For Procedure Codes 97024 (Diathermy) and 97035 (Ultrasound)

**Group 3 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A22.1</td>
<td>Pulmonary anthrax</td>
</tr>
<tr>
<td>A37.01</td>
<td>Whooping cough due to <em>Bordetella pertussis</em> with pneumonia</td>
</tr>
<tr>
<td>A37.11</td>
<td>Whooping cough due to <em>Bordetella parapertussis</em> with pneumonia</td>
</tr>
<tr>
<td>A37.81</td>
<td>Whooping cough due to other <em>Bordetella</em> species with pneumonia</td>
</tr>
<tr>
<td>A37.91</td>
<td>Whooping cough, unspecified species with pneumonia</td>
</tr>
<tr>
<td>A48.1</td>
<td>Legionnaires’ disease</td>
</tr>
<tr>
<td>B25.0</td>
<td>Cytomegaloviral pneumonitis</td>
</tr>
<tr>
<td>B44.0</td>
<td>Invasive pulmonary aspergillosis</td>
</tr>
<tr>
<td>B44.81</td>
<td>Allergic bronchopulmonary aspergillosis</td>
</tr>
<tr>
<td>B77.81</td>
<td>Ascariasis pneumonia</td>
</tr>
<tr>
<td>D57.01</td>
<td><em>Hb</em>-SS disease with acute chest syndrome</td>
</tr>
<tr>
<td>D57.211</td>
<td>Sickle-cell/Hb-C disease with acute chest syndrome</td>
</tr>
<tr>
<td>D57.411</td>
<td>Sickle-cell thalassemia with acute chest syndrome</td>
</tr>
<tr>
<td>D57.811</td>
<td>Other sickle-cell disorders with acute chest syndrome</td>
</tr>
<tr>
<td>J00 - J01.91</td>
<td>Acute nasopharyngitis [common cold] - Acute recurrent sinusitis, unspecified</td>
</tr>
<tr>
<td>J02.8 - J02.9</td>
<td>Acute pharyngitis due to other specified organisms - Acute pharyngitis, unspecified</td>
</tr>
<tr>
<td>J03.80 - J95.3</td>
<td>Acute tonsillitis due to other specified organisms - Chronic pulmonary insufficiency following surgery</td>
</tr>
<tr>
<td>J95.811 - J95.822</td>
<td>Postprocedural pneumothorax - Acute and chronic postprocedural respiratory failure</td>
</tr>
<tr>
<td>J95.84</td>
<td>Transfusion-related acute lung injury (TRALI)</td>
</tr>
<tr>
<td>J96.00 - J99</td>
<td>Acute respiratory failure, unspecified whether with hypoxia or hypercapnia - Chronic pulmonary insufficiency following surgery</td>
</tr>
<tr>
<td>M32.13</td>
<td>Lung involvement in systemic lupus erythematosus</td>
</tr>
<tr>
<td>M33.01</td>
<td>Juvenile dermatomyositis with respiratory involvement</td>
</tr>
<tr>
<td>M33.11</td>
<td>Other dermatomyositis with respiratory involvement</td>
</tr>
<tr>
<td>M33.21</td>
<td>Polymyositis with respiratory involvement</td>
</tr>
<tr>
<td>M33.91</td>
<td>Dermatopolymyositis, unspecified with respiratory involvement</td>
</tr>
<tr>
<td>M34.81</td>
<td>Systemic sclerosis with lung involvement</td>
</tr>
<tr>
<td>M35.02</td>
<td>Sicca syndrome with lung involvement</td>
</tr>
<tr>
<td>R09.1</td>
<td>Pleurisy</td>
</tr>
<tr>
<td>R09.81</td>
<td>Nasal congestion</td>
</tr>
</tbody>
</table>

**ICD-10 Additional Information**

**General Information**

**Associated Information**

**Documentation Requirements**

Please Note that complete discussion of the documentation requirements for therapy services can be found in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220-230.

To be payable, the medical record and the information on the claim form must consistently and accurately report covered therapy services, as documented in the medical record. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to the requirements in Medicare Manuals. Medicare requires that the services billed be
supported by documentation that justifies payment. Documentation must comply with all requirements applicable to Medicare claims.

These documentation guidelines in sections 220 and 230 of this chapter identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare Program. State or local laws and policies or the policies of the relevant profession, the practice or the facility may be more stringent. It is encouraged but not required that narratives that specifically justify the medical necessity of services be included in order to support approval when those services are reviewed.

Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

The medical record must indicate that the patient is under the care of a physician, nonphysician practitioner, or optometrist for the presenting diagnosis. (See CORF Guidelines specific to CORFs.)

The Plan of Care shall contain, at minimum, the following information as required by regulation [42 CFR 424.24, 410.61, and 410.105© (for CORFs) See Pub. 100-02, Chapter 15, section 220.3 for further documentation requirements].

- Diagnosis
- Long Term treatment goals; and
- Type, amount, duration and frequency of therapy services

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. Long Term treatment goals should be developed for the entire episode of care in the treatment setting. When the episode is anticipated to be long enough to require more than one certification, the long term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care. If the expected episode of care is short, for example therapy is expected to be completed in 4 to 6 treatment days, the long term and short term goals may be the same. In other instances measurable goals may not be achievable, such as when treatment in a particular setting is unexpectedly cut short (such as when care is transferred to another therapy provider) or when the beneficiary suffers an exacerbation of his/her existing condition terminating the current episode; documentation should state the clinical reasons progress cannot be shown. The type of treatment may be PT, OT, or SLP, or, where appropriate, the type may be a description of a specific treatment or intervention. Where a physician/NPP establishes a plan, the plan must specify the type (PT, OT, SLP) of therapy planned.

There shall be different plans of care for each type of therapy discipline. When more than one discipline is treating a patient, each must establish a diagnosis, goals, etc. independently. However, the form of the plan and the number of plans incorporated into one document are not limited as long as the required information is present and related to each discipline separately.

The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed. The frequency refers to the number of times in a week the type of treatment is provided. Where frequency is not specified, one treatment is assumed. The duration is the number of weeks, or the number of treatment sessions, for THIS PLAN of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting. The above policy describes the minimum requirements for payment. It is anticipated that clinicians may choose to make their plans more specific, in accordance with good practice. For example, they may include these optional elements: short term goals, goals and duration for the current episode of care, specific treatment interventions, procedures, modules or techniques and the amount of each. Also, notations in the medical record of beginning date for the plan are recommended but not required to assist Medicare contractors in determining the dates of service for which the plan was effective.
Certification/Re-certification Requirements (Pub 100-02, Chapter 15, Section 220.1.3 A-D. Please refer to this section of the manual for additional information and discussion).

The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility and/or practitioner. Acceptable documentation of certification may be, for example, a physician’s progress note, a physician/NPP order, or a plan of care that is signed and dated by a physician/NPP, and indicates the physician/NPP is aware that therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan when there is evidence the plan was sent (e.g., to the office) or is available in the record (e.g., of the institution that employees the physician/NPP) for the physician/NPP to review. For example, if, during the course of treatment under a certified plan of care a physician sends an order for continued treatment for 2 more weeks, contractors shall accept the order as certification of continued treatment for two more weeks under the same plan of care. If the new certification is for less treatment than previously planned and certified, this new certification takes the place of any previous certification. At the end of the 2 weeks (which might extend more than 2 calendar weeks from the date the order/certification was signed) of treatment another certification would be required if further treatment was documented as medically necessary.

Initial Certification

The physician’s/NPP certification of the plan (with or without and order) satisfies all of the certification requirements noted in 220.1 for the duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan. The provider or supplier (e.g., facility, physician/NPP, or therapist) should obtain certification as soon as possible after the plan of care is established, unless the requirements of delayed certification are met. "As soon as possible" means the physician/NPP shall certify the initial plan as soon as it is obtained, or within 30 days of the initial therapy treatment. Since payment may be denied if the physician does not certify the plan, the therapist should forward the plan to the physician as soon as it is established. Timely certification of the initial plan is met when the physician/NPP certification of the plan is documented, by signature or verbal order, and dated in the 30 days following the first day of treatment (including evaluation). If the order to certify is verbal, it must be followed within 14 days by a signature to be timely. A dated notation of the order to certify the plan of care should be made in the patient's medical record.

Review of Plan and Recertification

The timing of recertification changed on January 1, 2008. Certifications signed on or after January 1, 2008, follow the rules in this section. Certifications signed on or prior to December 31, 2007, follow the rule in effect at that time, which required recertification every 30 calendar days.

Payment and coverage conditions require that the plan must be reviewed, as often as necessary but at least whenever it is certified or recertified to complete the certification requirements. It is not required that the same physician/NPP who participated initially in recommending or planning the patient's care certify and/or recertify the plans. Recertifications that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after the initiation of treatment under that plan, unless they are delayed. A physician/NPP may certify or recertify a plan of care for what ever duration of treatment the physician/NPP determines is appropriate, up to a maximum of 90 calendar days. Many episodes of therapy treatment last less than 30 calendar days. Therefore, it is expected that the physician/NPP should certify a plan that appropriately estimates the duration of care for the individual, even if it is less than 90 days.

Restrictions on Certification. Certifications and recertifications by doctors of podiatric medicine must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable state law. Optometrists may order and certify only low vision services. Chiropractors may not certify or recertify plans of care for therapy services.

Note: Please see Pub. 100-02, Chapter 15, Section 220.1.3-D for further guidelines and requirements for delayed certification.

Evaluations (Pub 100-02, Chapter 15, Section 220.3C. Please refer to this section of the manual for additional information and complete discussion.)

EVALUATION is a separately payable comprehensive service provided by a clinician, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of
Documentation of the evaluation, should list the conditions and complexities and, where it is not obvious, describe the impact of the condition and complexities on the prognosis and/or the plan for treatment such that it is clear to the contractor who may review the record that services planned are appropriate for the individual.

Evaluations shall include:

- A diagnosis (where allowed by State and local law) and description of the specific problem(s) to be evaluated and/or treated. For PT and OT be sure to include the body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;
- Results of one of the following four measurement instruments are recommended but not required:
  - National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association
  - Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO)
  - Activity Measure Post Acute Care (AM-PAC)
  - OPTIMAL by Cedaron through the American Physical Therapy Association
- If the results of one of the four instruments listed above is not recorded, the record shall contain instead the following information indicated by asterisks(*) and should contain (but is not required to contain) all of the following, as applicable (for a list of examples for each of the following, please refer to Pub. 100-2, Chapter 15, Section 220.3):
  - Documentation supporting illness severity or complexity including, e.g.,
    - Identification of other health services concurrently being provided for this condition and/or
    - Identification of durable medical equipment needed for this condition, and/or
    - Identification of the number of medications the beneficiary is taking (and type if known); and/or
    - If complicating factors (complexities) affect treatment, describe why or how. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient's condition as reported on a functional measurement may be so great as to suggest extended treatment is anticipated; and/or
    - Generalized or multiple conditions.
    - Mental or cognitive disorder.
    - Identification of factors that impact severity including e.g., age, time since onset, cause of the condition, stability of symptoms, how typical/atypical are the symptoms of the diagnosed condition, availability of an intervention/treatment known to be effective, predictability of progress.
  - Documentation supporting medical care prior to the current episode, if any (or document none),
  - Documentation required to indicate beneficiary health related to quality of life, specifically,
    - The beneficiaries response to the following question of self-related health: "at the present time would you say that your health is excellent, very good, fair or poor?". If the beneficiary is unable to respond, indicate why; and
  - Documentation required to indicate beneficiary social support including specifically,
    - Where does the beneficiary live (or intend to live) at the conclusion of this outpatient therapy episode?
    - Who does the beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode?
    - Does the beneficiary require this outpatient therapy plan of care in order to return to a premorbid (or reside in a new) living environment, and
    - Does the beneficiary require this outpatient therapy plan of care in order to reduce ADL or IDAL assistance to a pre-morbid level or to reside in a new level of living environment (document prior level of independence and current assistance needs), and
  - *Documentation required to indicate objective, measurable beneficiary physical function including, e.g.,
    - Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
    - Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
Other measurable progress towards identifiable goals for functioning in the home environment at the conclusion of this therapy episode of care

- Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and
- A determination that treatment is not needed, or, if treatment is needed a prognosis for return to pre-morbid condition or maximum expected condition with expected time frame and a plan of care

Note: When the evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician.

Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. The time spent in evaluation shall not also be billed as treatment time. Evaluation minutes are untimed and are part of the total treatment minutes, but minutes of evaluation shall not be included in the minutes for times codes reported in the treatment notes.

Re-evaluations shall be included in the documentation sent to contractors when a re-evaluation has been performed. Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment if the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indication for re-evaluation includes new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued. A re-evaluation is focused on evaluation of progress towards goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Re-evaluations require the same professional skills as evaluation. The minutes for re-evaluation are documented in the same manner as minutes for evaluations.

TREATMENT NOTE (Pub 100-02, Chapter 15, Section 220.3E. Please refer to this section in the manual for additional information and complete discussion.)

The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim. Documentation is required for every treatment day, and every therapy service. The format shall not be dictated by contractor and may vary depending on the practice of the responsible clinician and/or the clinical setting.

The Treatment Note is not required to document the medical necessity or appropriateness of the ongoing therapy services. Descriptions of skilled interventions should be included in the plan or the Progress Reports and are allowed, but not required daily. Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff may be reported voluntarily as additional information if they are relevant and not billed.

Documentation of each treatment encounter will include the following required elements:

- Date of treatment;
- Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and
- Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time
does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbillable services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, chapter 5, section 20.2 for description of billing timed codes; and

- Signature and professional identification of the qualified professional who furnished or supervised the services and list of each person who contributed to treatment (i.e., the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law). The signature and identification of the supervisor need not be on each Treatment Note, unless the supervisor actively participated in the treatment. Since a clinician must be identified on the Plan of Care and the Progress Report, the name and professional identification of the supervisor responsible for the treatment is assumed to be the clinician who wrote the plan or report.

If a treatment is added or changed under the direction of a clinician during the treatment days between the interval progress reports, the change must be recorded and justified on the medical record, either in the treatment note or the progress note, as determined by the policies of the provider/supplier. New exercises added or changes made to exercise program help justify that the services are skilled. For example: The original plan was for therapeutic activities, gait training and neuromuscular re-education. "On Feb. 1 clinician added electrical stimulation to address shoulder pain."

Documentation of each treatment encounter may also include the following optional elements to be mentioned only if the qualified professional recording the note determines they are appropriate and relevant:

- Patient self-report;
- Adverse reaction to intervention;
- Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.);
- Significant, unusual or unexpected changes in clinical status;
- Equipment provided; and/or
- Any additional relevant information the qualified professional finds appropriate.

See CMS IOM Pub. 100-04, chapter 5, section 20.2 for instructions on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as un-timed codes.

**FUNCTIONAL REPORTING**

For a complete outline of the CMS Requirements regarding Functional Reporting, please refer to Pub 100-04, Medicare Claims Processing Manual, Chapter 5, Section 10.6.


**A. General**

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the Act to require a claims-based data collection system for outpatient therapy services, including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. 42 CFR 410.59, 410.60, 410.61, 410.62 and 410.105 implement this requirement. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures.

Beneficiary function information is reported using 42 nonpayable functional G-codes (G8978-G8999, G9158-G9176, and G9186) and seven severity/complexity modifiers (CH-CN) on claims for PT, OT, and SLP services. Functional reporting on one functional limitation at a time is required periodically throughout an entire PT, OT, or SLP therapy episode of care.

**PROGRESS REPORT** (Pub 100-02, Chapter 15, Section 220.3D. Please refer to this section in the manual for additional information and complete discussion)
The Progress report provides justification for the medical necessity of treatment. Contractors shall determine the necessity of services based on the delivery of services as directed in the plan and as documented in the Treatment Notes and Progress Report. For Medicare payment purposes, information required in Progress Reports shall be written by a clinician, that is either the physician/NPP who provides or supervises the services, or by the therapist who provides the services and supervises an assistant. It is not required that the referring or supervising physician/NPP sign the Progress Report written by a PT/OT or SLP.

**Timing**

The minimum Progress Report Period shall be at least once every 10 treatment days. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation or treatment. Regardless of the date on which the report is actually written (and dated), the end of the Progress Report Period is either a date chosen by the clinician, or the 10th treatment day, whichever is shorter. The next treatment day begins the next reporting period. The Progress Report Period requirements are complete when both the elements of the Progress Report and the clinician's active participation in treatment have been documented. (See Pub 100-02, Medicare Benefit Policy, Chapter 15, Section 220-230 for these definitions and requirements and for completer discussion related to holidays, absences, delayed reports, early reports).

It should be emphasized that the dates for recertification of plans of care do not affect the dates for required Progress Reports. (Consideration of the case in preparation for a report may lead the therapist to request early recertification. However, each report does not require recertification of the plan, and there may be several reports between recertifications.)

Elements of Progress reports may be written in the Treatment Notes if the provider/supplier or clinician prefers. If each element required in a Progress Report is included in the Treatment Notes at least once during the Progress Report Period, then a separate Progress Report is not required. Also, elements of the Progress Report may be incorporated into a revised Plan of care when one is indicated. Although the Progress Report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the revised Plan of Care accompanied by the Progress Report Shall be re-certified by a physician/NPP. See section 220.1.2C, Changes to the Therapy Plan, for guidance on when a revised plan requires certification.

**Documenting Clinician Participation in Treatment in the Progress Report**

Verification of the clinician's required participation in treatment during the Progress Report Period shall be documented by the clinician's signature on the Treatment Note and/or on the Progress Report. When unexpected discontinuation of treatment occurs, contractors shall not require a clinician's participation in treatment for the incomplete reporting period.

The Discharge Note (or Discharge Summary) is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The Discharge Note shall be a Progress Report written by a clinician, and shall cover the reporting period from the last Progress Report to the date of discharge. In the case of a discharge unanticipated in the plan or previous Progress Report, the clinician may base any judgments required to write the report on the Treatment Notes and verbal reports of the assistant or qualified personnel.

In the case of a discharge anticipated within 3 treatment days of the progress report, the clinician may provide objective goals which, when met, will authorize the assistant or qualified personnel to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist, and services were provided or supervised by a clinician. The discharge note shall include all treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge.

At the discretion of the clinician, the discharge note may include additional information; for example, it may summarize the entire episode of treatment, or justify services that may have extended beyond those usually expected for the patient's condition. Clinicians should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed. The record should be reviewed and organized so that the required documentation is ready for presentation to the contractor if requested.

**Assistant's Participation in the Progress Report**
PTAs and OTAs may write elements of the Progress Report dated between clinician reports. Reports written by assistants are not complete Progress Reports. The clinician must write a Progress Report during each Progress Report Period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the clinician's report. Progress Reports written by assistants supplement the reports of clinicians and shall include:

- Date of the beginning and end of the reporting period that this report refers to;
- Date that the report was written (not required to be within the reporting period);
- Signature, and professional identification, or for dictated documentation, the identification of the qualified professional who wrote the report and the date on which it was written or dictated;
- Objective reports of the patient's subjective statements, if they are relevant. For example, "Patient reports pain after 20 repetitions". Or, "The patient was not feeling well on 11/05/06 and refused to complete the treatment session."; and
- Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively. For example: "increasing strength" is not an objective measurement, but "patient ambulates 15 feet with maximum assistance" is objective.

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the Progress Report may be used to add, change or delete short term goals.

Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name and date. Clinicians verify these changes by co-signatures on the report or in the clinician’s Progress Report. (See section 220.1.2(C) to modify the plan for changes in long term goals).

The evaluation and plan of care are considered incorporated into the Progress Report, and information in them is not required to be repeated in the report. For example, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current progress report period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3, ) and the short term goals that relate to the long term goals may be numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. A clinician, an assistant on the order of a therapist or qualified personnel on the order of a physician/NPP shall add new goals with new identifiers or letters. Omit reference to a goal after a clinician has reported it to be met, and that clinician’s signature verifies the change.

**Content of Clinician (Therapist, Physician/NPP) Progress Reports**

In addition to the requirements above for notes written by assistants, the progress report of a clinician shall also include:

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report; and
- Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.

A re-evaluation should not be required before every Progress Report routinely, but may be appropriate when assessment suggests changes not anticipated in the original plan of care.

Care must be taken to assure that documentation justifies the necessity of the services provided during the reporting period, particularly when reports are written at the minimum frequency. Justification for treatment must include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.
Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justification for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.

The progress notes must contain necessary and sufficient information, which indicates the services were actually provided and were reasonable and necessary to treat the patient's condition. Progress notes must substantiate the medical necessity of the treatment and support that skilled intervention is required.

The progress note should document any treatment variations with the associated rationale.

The progress notes should be written using measurements and functional accomplishments. Use statements which can be used to assess the patient's response to therapy such as:

- "able to perform exercises as prescribed for 15 reps"
- "able to safely transfer from bed to wheelchair with standby assistance"
- "can now abduct shoulder 120 degrees"
- "can bridge now sufficiently to pull slacks up over hips"

Avoid terms such as:
- doing well
- improving
- less pain
- increased range of motion
- increased strength
- tolerated treatment well

Documentation Requirements for specific modalities:

**Iontophoresis (CPT code 97033)/Phonopheresis (CPT code 97035)**

The name and dosage of the medication utilized during Phonopheresis (97035) or Iontopheresis (97033) should be maintained in the medical record. This information may be indicated in the plan of treatment or on a prescription signed by the health care provider responsible for certifying the plan of treatment.

**Therapeutic Exercise (CPT code 97110)**

Documentation for therapeutic exercise (97110) must show objective loss of joint motion, strength, mobility (e.g., degrees of motion, strength grades, levels of assistance).

**Therapeutic Procedure(s), group (2 or more individuals) (CPT code 97150)**

Documentation must be maintained in the patient's medical record identifying the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, and the treatment goal in the individualized plan. The number of persons in the group must also be furnished.

Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individual can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

**Wheelchair Management (CPT Code 97542)**

When billing 97542 for wheelchair propulsion training, documentation must relate the training to expected functional goals that are attainable by the patient.

**Physical Performance Test or Measurement (CPT code 97750)**
The health care provider performs a test of physical performance evaluating function of one or more body areas and evaluates functional capacity. A written report is included. This is in addition to a routine evaluation or re-evaluation (97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168).

**Assistive Technology Assessment (CPT code 97755)**

The medical record should document the goal of the assessment, the technology/component/system involved, a description of the process involved in assessing the patient’s response, the outcome of the assessment, and how this information affects the treatment plan.

**Prosthetic Training (CPT code 97761)**

The medical record should document the distinct treatments rendered when prosthetic(s) training for a lower extremity is done during the same visit as gait training (CPT code 97116) or self-care/home management training (CPT code 97535).

Periodic revisits beyond the third month may require documentation to support medical necessity.

One would not expect to see more than 30 minutes of prosthetic training billed on a given date. The medical record must document the medical necessity of the additional time.

**Documentation Requirements for Complex Decongestive Physiotherapy**

The medical record documentation maintained by the provider must clearly document the medical necessity of the services being performed.

The documentation for the initial evaluation and treatment must include the following:

- a physician documented diagnosis of lymphedema and a specific order for CDP.
- a statement as to the ability of the patient/patient caregiver to follow through with the continuation of treatment on a long term home treatment plan.
- history and physical including: the cause of the lymphedema and any prior treatment, measurements of body part/extremity prior to treatment, specific areas of indurated tissue, hardness of edema, condition of nails and skin, infected sites, scars, distal pulses, pain, discomfort and the affects the lymphedema has on the patient's Activities of Daily Living (i.e, symptomatic for lymphedema, with limitation of function related to self care, mobility and/or safety).
- treatment plan identifying specific short and long term goals; the type, amount, frequency and duration of the services.
- the services/modalities performed including a response to treatment.

The documentation for any subsequent treatment must include:

- a report showing the progress of the therapy including periodic measurements of the applicable extremity(ies).
- the response of the patient/patient caregiver to the education and their understanding and ability to take on some of the responsibilities of the treatment.
- the services/modalities performed including a response to treatment.

For additional documentation guidelines for outpatient rehabilitation services see Pub. 100-02, Medicare Benefit Policy, Chapter 15, Sections 220 and 230.

For Comprehensive Outpatient Rehabilitation Facility (CORF) coverage see Pub. 100-02, Medicare Benefit Policy, Chapter 12, and Pub. 100-04, Medicare Claims Processing Manual, Chapter 5.

For additional information on the financial limitation, please see Pub. 100-04, Medicare Claims Processing Manual, Chapter 5, Sections 10.2-10.5.

**Utilization Guidelines**

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject
to review for medical necessity.

**Sources of Information**

First Coast Service Options, Inc. reference LCD numbers L29024, L29289, L29399


Bollinger, K. (2004). Manual therapy can help patients progress to functional therapeutic exercise. Advance newsmagazines. PA: Merion Publications. This source was used to gain a better understanding of manual therapy.


Scifers, J. (2004). Among modalities, use iontophoresis to quickly relieve pain and inflammation. Advance newsmagazines. PA: Merion Publications. This source was used to gain a better understanding of iontophoresis therapy.

Tan, J.C. (1998). Practical manual of physical medicine and rehabilitation. St. Louis, MO: Mosby, Inc. This source was used to clarify the various modalities.

**Bibliography**

N/A

### Revision History Information

<table>
<thead>
<tr>
<th>Revision History Date</th>
<th>Revision History Number</th>
<th>Revision History Explanation</th>
<th>Reason(s) for Change</th>
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<tbody>
<tr>
<td>04/24/2018</td>
<td>R13</td>
<td>Revision Number: 8 Publication: May 2018 Connection LCR A/B2018-040</td>
<td>• Other (Revisions based on annual review completed on 12/20/2017.</td>
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<td>Explanation of revision: Based on an annual review of the LCD, it was determined that some of the italicized language in the “Coverage Indications, Limitations, and/or Medical Necessity” and “Documentation Requirements” sections of the LCD do not represent direct quotation from CMS sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources. The effective date of this revision is based on date of service.</td>
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<td>04/24/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage</td>
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<td>which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
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<tr>
<td>02/23/2018</td>
<td>R12</td>
<td>Revision Number: 7 Publication: March 2018 Connection LCR A/B2018-025 Explanation of revision: Section 50202 of the Bipartisan Budget Act repeals Medicare provisions affecting the outpatient therapy caps. This section requires that Medicare claims no longer be subject to the therapy cap. Therefore, the “Indications and Limitations of Coverage and/or Medical Necessity,” “CPT/HCPCS Codes,” and “ICD-10 Codes that Support Medical Necessity” sections of the LCD were revised to remove language related to the therapy cap. The effective date of this revision is based on claims processed on or after February 23, 2018, for dates of service on after January 1, 2018. Also, based on CR10318 (NCD 270.1), the LCD was revised to add non-pressure chronic ulcers as covered for HCPCS code G0281 in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. The effective date of this revision is based on claims processed on or after April 2, 2018, for dates of service on after October 1, 2017. 02/23/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
<td>• Provider Education/Guidance • Public Education/Guidance</td>
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<td>01/01/2018</td>
<td>R11</td>
<td>Revision Number: 6 Publication: December 2017 Connection LCR A/B2018-011 Explanation of revision: Annual 2018 HCPCS update and CR 10303 (2018 Annual Update to the Therapy Code List). Descriptor revised for CPT codes 97760 and 97761. Also, CPT code 97532 was deleted and replaced with HCPCS code G0515 and CPT code 97762 was deleted and replaced with CPT code 97763. The effective date of this revision is based on date of service. In addition, a determination was made to remove unlisted CPT codes 97039, 97139, and 97799 from the “Indications and Limitations of Coverage and/or Medical Necessity” and “CPT/HCPCS Codes” sections of the LCD. The language related to “Unlisted Modalities” was also removed from the “Documentation Requirements” section of the LCD. The effective date of this revision is based on process date.</td>
<td>• Revisions Due To CPT/HCPCS Code Changes</td>
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<td>10/01/2017</td>
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<td>Revision Number: 5</td>
<td>• Revisions Due To ICD-10-CM Code Changes</td>
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<td>Publication: September 2017 Connection LCR A/B2017-038</td>
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<td>Explanation of Revision: Based on CR 10153 (Annual 2018 ICD-10-CM Update) the LCD was revised. Descriptor revised for ICD-10-CM diagnosis codes M33.01, M33.11 for procedure codes 97024, 97035. The effective date of this revision is based on date of service.</td>
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<td>10/01/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
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<td>01/20/2017</td>
<td>R9</td>
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<td>Publication: January 2017 Connection LCR A/B2017-003</td>
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<td>Explanation of Revision: The LCD was revised based on CR 9861 to remove all associated language and diagnosis codes for CPT code 97026 as infrared therapy is noncovered for all indications. The effective date of this revision is for claims processed on or after 01/20/2017 for dates of service on or after 10/01/2015.</td>
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<td>Explanation of Revision: Annual 2017 HCPCS Update. LCD was revised to add CPT codes 97161-97168. Additionally, LCD was revised to delete CPT codes 97001-97004. The effective date of this revision is based on date of service.</td>
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<td>Publication: October 2016 Connection LCR A/B2016-097</td>
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<td>03/15/2016</td>
<td>R5</td>
<td>Explanation of revision: Based on an internal request to clarify language in the LCD under the Documentation section in the LCD pertinent to CPT code 97750, the LCD has been revised to clarify this section. The effective date of this revision is based on date of service.</td>
<td>• Reconsideration Request</td>
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<td>10/01/2015</td>
<td>R4</td>
<td>8/28/15 The language and/or ICD-10-CM diagnoses were updated to be consistent with the current ICD-9-CM LCD’s language and coding.</td>
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<td>10/01/2015</td>
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<td>06/05/2014 – The language and/or ICD-10-CM diagnoses were updated to be consistent with current LCD language and ICD-9-CM coding.</td>
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**Associated Documents**

Attachments
N/A

Related Local Coverage Documents
Article(s)
A55920 - Therapy and rehabilitation services revision to the Part A and Part B LCD

**Keywords**

N/A