Authorization Criteria for Outpatient Physical Therapy

DISCLAIMER

Our medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

Note: The availability of rehabilitative and/or habilitative benefits for these services, state and federal mandates, and regulatory requirements should be verified prior to application of criteria listed below. Benefit plans may include a maximum allowable physical therapy benefit, either in duration of treatment or in number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met.

Requests for coverage of Physical Therapy (PT) Services beyond pre-determined benchmarks, guidelines, or benefit parameters may be considered depending on the specific terms of a member’s contract, or under the direction of an employer group. When this is the case, ongoing coverage of PT services, up to benefit limitations, may be evaluated using the following medical necessity criteria.

POLICY

Requests for coverage of PT services (as allowed according to the terms of the member’s contract) may be considered medically necessary when services meet all of the following criteria:

- meet the continued functional needs of a patient who suffers from physical impairment due to disease, trauma, congenital anomalies, or prior therapeutic intervention;
- achieve a specific diagnosis-related goal for a patient who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time;
- provide specific, effective, and reasonable treatment for the patient’s diagnosis and physical condition;
- are delivered by a qualified provider of physical therapy services. A qualified provider is one who is licensed where required and performs within the scope of licensure; and,
- require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the patient.

Requests for coverage of PT services not meeting these criteria will be considered not medically necessary unless otherwise excluded or denied under other benefit plan or medical policy criteria.

Duplicate Therapy

Duplicate therapy is considered not medically necessary. When patients receive both physical and occupational therapy, the therapies should provide different treatments and not duplicate the same
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Treatment. They must also have separate treatment plans and goals.

**Non-skilled Therapy**
Certain types of treatment do not generally require the skills of a qualified provider of PT services and are therefore **not medically necessary**. Services may include:

- passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function;
- any of the following treatments when given alone or to a patient who presents no complications: hot packs; hydrocollator; infrared heat; whirlpool baths; paraffin baths; Hubbard tank; cold packs; ice packs; and contrast baths.

Benefits for these services may be denied.

A determination of medical necessity through the criteria outlined in this medical policy, does not necessarily result in a determination that a service or treatment is payable under the terms of the applicable benefit plan.

**POLICY GUIDELINES**

**Classification of Severity of Conditions**
Severity is classified as mild, moderate and severe conditions. Severity is determined by various factors as noted in the following table.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Mild Condition</th>
<th>Moderate Condition</th>
<th>Severe Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mode of onset</td>
<td><em>Variable</em></td>
<td>Variable</td>
<td>Severe</td>
</tr>
<tr>
<td>Anticipated duration of Care</td>
<td>1-6 weeks</td>
<td>6-10 weeks</td>
<td>10 or more weeks</td>
</tr>
<tr>
<td>Functional deficits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Range of motion</td>
<td>Mild/no loss</td>
<td>Mild to moderate loss</td>
<td>Considerable loss</td>
</tr>
<tr>
<td>2. Muscle strength</td>
<td>Mild/no loss</td>
<td>Mild to moderate loss</td>
<td>Considerable loss</td>
</tr>
<tr>
<td>3. Neurologic findings</td>
<td>None</td>
<td>May be present</td>
<td>May be present</td>
</tr>
<tr>
<td>4. ADL- including: walking, dressing, bathing, eating, grooming, toileting, and transferring</td>
<td>Mild/no loss</td>
<td>Mild to moderate</td>
<td>Moderate to severe</td>
</tr>
<tr>
<td>Loss of work days</td>
<td>No loss of work days</td>
<td>0-4 days of work lost</td>
<td>5 or more days of work lost</td>
</tr>
<tr>
<td>Work restriction</td>
<td>None</td>
<td>Possible, depends on occupation; 0-2 weeks</td>
<td>Restriction, depends on occupation; 2 or more weeks</td>
</tr>
</tbody>
</table>

Table 1- Criteria for condition severity classification

**Sessions**
A physical therapy session is defined as up to 1 hour of PT (treatment and/or evaluation) or up to 3 PT modalities provided on any given day. These sessions may include:
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- therapeutic exercise programs, including coordination and resistive exercises, to increase strength and endurance;
- various modalities including, but not limited to, thermotherapy, cryotherapy, hydrotherapy, and electrical stimulation;
- massage, traction, or mobilization techniques; and
- patient and family education in home exercise programs.

Plan of Care

The plan of care should include:

- specific statements of long- and short-term goals;
- measurable objectives;
- a reasonable estimate of when the goals will be reached;
- the specific modalities and exercises to be used in treatment; and
- the frequency and duration of treatment.

The plan of care should be updated as the patient's condition changes and should be recertified at least every 30 days.

BENEFIT APPLICATION

BLUECARD/NATIONAL ACCOUNT ISSUES

The availability of rehabilitative and/or habilitative benefits for these services, state and federal mandates, and regulatory requirements should be verified prior to application of criteria listed below. Benefit plans may include a maximum allowable physical therapy benefit, either in duration of treatment or in number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met.

Benefits and administrative requirements vary by benefit plan. Check the benefit plan for any administrative requirements or extension of benefit provisions. If a benefit plan allows for extension of a PT benefit, prior authorization for such extensions is required to facilitate claim payment based on a review of the written plan of care.

BACKGROUND

This document addresses physical therapy (PT) services, skilled services which may be delivered by a physical therapist or other healthcare professional acting within the scope of a professional license. Physical therapy is used for both rehabilitation and habilitation.

Rehabilitative services are intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time. Benefits will end when treatment is no longer medically necessary and the individual stops progressing toward those goals.

Habilitative services are intended to maintain, develop or improve skills needed to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs), which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality. Examples include therapy for a child who is not walking at the expected age.

The terms "physical therapy" and "physiotherapy" are synonymous.
RATIONALE

This policy was originally created in 1997. Since that time the policy has been reviewed and updated using MEDLINE literature searches. The most recent update with literature review was through April, 2016. Following is a summary of the key literature.

Physical therapy consists of treatment modalities prescribed to restore lost functional ability. Some of the therapeutic interventions include heat and cold, electrical stimulation, massage, therapeutic exercises, traction, gait training for ambulation and training in other functional activities. There are case studies found, however, few RCTs exist that address physical therapy modalities/manual medicine treatment as distinct from a comprehensive rehabilitation program.

In 2007, Taylor and colleagues summarized the benefits of therapeutic exercise based on a systematic review of the literature published from 2002-2005. The review extracted 36 studies that were classified into groups based on condition. The conditions were 6-cardiopulmonary, 6-neurology, 20-musculoskeletal (including: spinal n=7; peripheral n=9, arthritis n=4), and 4-other. Therapeutic exercise was found to be effective for patients with multiple sclerosis, osteoarthritis, subacute and chronic low back pain, chronic heart failure, coronary heart disease, chronic heart failure, coronary heart disease, chronic obstructive pulmonary disease (COPD), and intermittent claudication and after lumbar disc surgery. Outcomes measured the effect of therapeutic exercise in terms of physical impairment, and restriction or limitation to active participation in ADLs. The conclusions state that focused, patient-centered therapeutic exercise programs were effective; however, some of the trials were of poor quality.

MEDICARE NATIONAL COVERAGE

“Part A covers medically necessary physical therapy services that are ordered by a physician under home health services if the patient is homebound. Part B helps pay for medically necessary outpatient physical therapy services that are ordered by a physician. Physical therapy services: include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached.”

PRACTICE GUIDELINES AND POSITION STATEMENTS

American Physical Therapy Association (APTA)
The APTA publishes positions and policies, the most recent revisions are available at www.apta.org. It includes Guidelines for Physical Therapy Documentation:

“It is the position of the APTA that physical therapist examination, evaluation, diagnosis, and prognosis shall be documented, dated, and authenticated by the physical therapist that performs the service.”

“Intervention provided by the physical therapist or physical therapist assistant, under direction and supervision of a physical therapist, is documented, dated, and authenticated by the physical therapist who performs the service or, when permissible by the law, the physical therapy assistant.”

REFERENCES


Authorization Criteria for Outpatient Physical Therapy


**CODES**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT</td>
<td>97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028</td>
<td>Physical medicine and rehabilitation modalities, supervised, code range.</td>
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<td>97032, 97033, 97034, 97035, 97036, 97039</td>
<td>Physical medicine and rehabilitation modalities, constant attendance, code range.</td>
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<td>97110, 97112, 97113, 97116, 97124, 97139</td>
<td>Therapeutic procedures code range.</td>
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<tr>
<td></td>
<td>97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97169, 97170, 97171, 97172</td>
<td>Physical medicine and rehabilitation evaluation and re-evaluation code range</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Q0086</td>
<td>Physical therapy evaluation/treatment, per visit</td>
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</tbody>
</table>

**Type of Service** 
Therapy

**Place of Service** 
Outpatient

Home
## POLICY HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Reason</th>
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<tr>
<td>12/23/16</td>
<td>Add to Therapy section: Rehabilitation subsection</td>
<td>New policy; criteria for outpatient PT added.</td>
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<tr>
<td>12/27/17</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho annual review, no change to policy.</td>
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<tr>
<td>03/29/18</td>
<td>Update only</td>
<td>Medical policy renumbered from 8.03.02 to 8.03.502.</td>
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<tr>
<td>11/15/18</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho annual review; no change to policy statements.</td>
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