Therapy Services (PT, OT, SLP)

LCD/LMRP

Effective Date: 5/17/2010
Status: Active
Revision Date: 1/1/2011

LCD Title
Therapy Services (PT, OT, SLP) – 4Y-26AB-R8

Contractor’s Determination Number
4Y-26AB (L26832)

Contractor Name
TrailBlazer Health Enterprises

Contractor Number
• 04001 (04101, 04201, 04301, 04401, 04901).
• 04002 (04102, 04202, 04302, 04402).

Contractor Type
• MAC – Part A.
• MAC – Part B.

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CMS National Coverage Policy
This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for therapy services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for therapy services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding therapy services are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

• Medicare Benefit Policy Manual – Pub. 100-02, Chapters 6, 8 and 15.
• Medicare Claims Processing Manual – Pub. 100-04, Chapter 5:
  • Section 10 – Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General.
  • Section 20 – HCPCS Coding Requirement.
• Medicare Program Integrity Manual – Pub. 100-08, Chapter 13:
  • Sections 220 and 230.
• Medicare National Coverage Determinations Manual – Pub. 100-03.
• Correct Coding Initiative – Medicare Contractor Beneficiary and Provider Communications Manual – Pub. 100-09, Chapter 5.
• Social Security Act (Title XVIII) Standard References, Sections:
  • 1862(a)(1)(A) Medically Reasonable & Necessary.
  • 1862(a)(1)(D) Investigational or Experimental.
Primary Geographic Jurisdiction

- CO
- NM
- OK
- TX:
  - Indian Health Service.
  - End Stage Renal Disease (ESRD) facilities.
  - Skilled Nursing Facilities (SNFs).
  - Rural Health Clinics (RHCs).
- Transitioned WPS legacy providers.

Oversight Region

- Region IV.
- Region VI.

Original Determination Effective Date

05/17/2010

Original Determination Ending Date

N/A

Revision Effective Date

01/01/2011

Revision Ending Date

N/A

Indications and Limitations of Coverage and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered.

This LCD supplements but does not replace, modify or supersede Medicare payment policy rules and regulations for therapy services. Neither Medicare payment policy rules nor this LCD replace, modify or supersede state statutes regarding the definitions and/or scopes of practice for physicians, qualified Non-Physician Practitioners (NPPs), Physical Therapists (PTs), Occupational Therapists (OTs), Speech-Language Pathologists (SLPs), physical therapy assistants and others who are licensed to perform specific skilled therapy services. Federal statute and subsequent Medicare regulations regarding provision and payment for therapy services are lengthy. They are not completely repeated in this LCD. All providers who report therapy services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:


The cornerstones of rehabilitative therapy are mobilization, education and therapeutic exercise. The goal of rehabilitative medicine is discernible, functional progress toward the restoration or maximization of impaired neuromuscular and musculoskeletal function. To that end, the dynamic component of therapy, mobilization and patient education should predominate. Passive modalities should be used in the “warm-up” phase of the patient encounter as preparation for or as an adjunct to therapeutic procedures, and in the “cool-down” phase for reduction of pain, swelling and other post-treatment syndromes. Though passive modalities may predominate in the earlier phases of rehabilitation where the patient’s ability to participate in therapeutic exercise is restricted, Medicare expects these modalities to never be the sole or predominant constituent of a therapy plan of care. Further, Medicare expects the patient’s record to clearly reflect medical necessity for passive modalities, especially those that exceed 25 percent of the cumulative service hours of rehabilitative therapy provided for any beneficiary under a plan of care.

Complicating factors that may influence treatment, e.g., they may influence the type, frequency and/or duration of treatment, may be represented by diagnoses (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 5, Section 10.2.C.3); by patient factors such as age, severity, acuity, multiple conditions, co-morbidities, and
motivation; or by the patient’s social circumstances, such as the support of a significant other or the availability of transportation to therapy.

In more refractory cases, the practitioner will support the need for continued care with documentation that clearly outlines the factors that affect the rate of recovery and reinforces the anticipation that further functional gain is expected. The contractor recognizes variability in strength, recovery time and the ability to be educated, and allows for a recertification for additional therapy, as long as adequate medical documentation by the supervising physician or therapist is recorded in the medical record and the patient continues to demonstrate progress.

In all cases, whether the duration and intensity of rehabilitative services rendered are limited or extensive, Medicare expects the patient’s medical record to clearly demonstrate medical reasonableness and necessity for all therapy services, both active and passive. If an individual’s expected rehabilitation potential is insignificant, or the patient's maximum rehabilitation potential have been realized, therapy is not reasonable and necessary and should not be reported to Medicare as a payable service.

Though this LCD establishes limitations to duration and intensity of outpatient rehabilitation, Medicare expects that most patients will not require maximum numbers of services. Providing maximal services as a routine is of concern and will result in Medicare auditing.

**General Physical Medicine & Rehabilitation (PM&R) Guidelines**

This LCD applies to the therapy services coded with the 97XXX series of CPT codes. Per CMS definitions, therapy services include these services with a few exceptions. Please refer to the documents found at [http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage](http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage) for the complete listing of CPT codes that are “always” considered therapy services and those that are “sometimes” considered therapy services for coverage, requirement for plan of care, and coding purposes.

Intervention with Physical Medicine and Rehabilitation (PM&R) modalities and procedures is indicated when an assessment by a physician, NPP and/or therapist supports utilization of the intervention, there is documentation of objective physical and functional limitations (signs and symptoms), and the written plan of care incorporates those treatment elements that are expected to result in improvement of these limitations in a reasonable and generally predictable period of time. PM&R services must be furnished on an outpatient basis and provided while the patient is or was under the care of a physician or NPP.

Medicare covers therapy services **personally** performed **only** by one of the following:

- Licensed therapy professionals: licensed PTs, OTs and SLPs.
- Licensed physical therapy assistants when supervised directly by a licensed PT.
- Licensed occupational therapy assistants when supervised directly by a licensed OT.
- Medical Doctors (MDs) and Doctors of Osteopathy (DOs).
- Doctors of Optometry (ODs) and Podiatric Medicine (DPMs) when performing services within their licenses’ scope of practice and their training and competency.
- Qualified NPPs, including Advanced Nurse Practitioners (ANPs), Physician Assistants (PAs) or Clinical Nurse Specialists (CNS)) when performing services within their licenses’ scope of practice and their training and competency (ANP, PA, CNS).
- “Qualified” personnel when directly supervised by a physician (MD, DO, OD, DPM) or qualified NPP, and when all conditions of billing services “incident to” a physician have been met. Qualified personnel have met the educational and degree requirements of a licensed therapy professional (PT, OT, SLP), but are not required to be licensed. **Please note that unless these therapy services are performed by a “qualified” person, the services are not covered and must not be reported for Medicare payment.**

**Other specific requirements include the following:**

- Medicare covers therapy services that require the skill of a trained and licensed practitioner to perform or supervise. Medicare does not cover therapy services that do not require the skill of a trained and licensed practitioner to perform **even when** one of the persons in the list above performs them.
- A written plan of care, consisting of diagnoses (long-term treatment goals and type, amount, duration and frequency of therapy services), must be established by the physician, NPP or therapist providing the services before the services are begun.
- The plan must be periodically reviewed by the physician or NPP.
- A therapist may not significantly alter a plan of care established or certified by the physician or NPP without their documented written or verbal approval.
  - The plan must be certified and recertified periodically (see “Documentation Requirements” for details) by the physician or NPP. New or significantly modified plans of care must be certified within 30 calendar days after the initial treatment under that plan, unless delayed certification criteria are met.
  - If certification is obtained verbally, it must be followed by a signature within 14 days to be timely.
  - Recertifications must be obtained within the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.
Services provided concurrently by a physician, PT and OT may be covered if separate and distinct goals are documented in the treatment plans.

- The type, frequency and duration of services must be medically necessary for the patient's condition under accepted medical, physical therapy and occupational therapy practice standards and relate directly to a written treatment plan. There must be an expectation that the condition or level of function will improve within a reasonable (and generally predictable) time or the services must be necessary to establish a safe and effective maintenance regimen required in connection with a specific disease.

It is not medically necessary for a qualified professional to perform or supervise maintenance programs that do not require the professional skills of a qualified professional. 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 or unstable patients.
- 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.
- Maintenance therapies after the patient has achieved therapeutic goals or for patients who show no further meaningful progress and should become patient- or caregiver-directed.

For all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Treatment times per session vary based upon the patient's medical initial therapy needs and progress to date toward established goals. Treatment times per session typically will not exceed 45–60 minutes. Additional time is sometimes required for more complex and/or slow-to-respond patients. However, documentation of the exceptional circumstances must be maintained in the patient's medical record and available upon request.

For purposes of this policy, a "service" is defined as a 15-minute billing increment of a specific therapy CPT code. For codes that are defined as per 15 minutes or each 15 minutes, Medicare would not expect to see the qualified professional billing per treatment site. Report these codes based on the actual amount of time spent on a cumulative basis for the specified modality or procedure. For additional information, review unusual length of time issues in the "Documentation Requirements" section of this policy.

For claims submitted by a physician or NPP:

- Services performed by non-employees or those not under a physician’s or NPP’s direct supervision are not covered.
- Services not relating to a written treatment plan are not medically necessary.
- Services that do not require the professional skills of a physician or NPP to perform or supervise are not medically necessary.

For claims submitted by a Physical or Occupational Therapist (PT or OT) or Speech-Language Pathologist (SLP) in independent practice:

- An order, sometimes called a referral, for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.
- Claims submitted by anyone other than a therapist enrolled as a Medicare provider are not covered.
- Services not performed by or under the direct supervision of the therapist are not covered.
- Services performed by people who are not employees of the therapist are not covered.
- Services not furnished in the therapist's office or in the patient's home are not covered.
- Physical therapy services that do not require the professional skills of a qualified (PT) to perform or supervise are not medically necessary.
- Occupational therapy services that do not require the professional skills of a qualified OT to perform or supervise are not medically necessary.
- Speech-language pathology services that do not require the professional skills of a qualified SLP to perform...
Maintenance Therapy

Maintenance therapy after therapeutic goals and/or rehabilitative potentials are reached is medically reasonable and necessary but is not covered. However, a qualified professional may develop a maintenance program for the patient to pursue outside of a therapy program and plan of care, generally administered and supervised by family 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 qualified professional are required. Examples include:

- Design of a maintenance regimen required to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease.
- Instructing the patient, family member(s) or caregiver(s) in carrying out the maintenance program.
- Infrequent re-evaluations required to assess the patient’s condition and adjust the program.

If a maintenance program is not established until after the therapy program has been completed (and the skills of a therapist are not necessary), development of a maintenance program is not considered reasonable and necessary for the patient’s condition.

Note: Bill these services (e.g., codes 99212–99215, 97002, 97004) with the appropriate evaluation/re-evaluation. It is expected these services will be infrequently required.

General Modality Guidelines (Codes 97012 and 97018–97039)

- Modality codes 97012© (mechanical traction) and 97016©–97028© (vasopneumatic device, paraffin bath therapy, whirlpool therapy, diathermy, and ultraviolet therapy) require supervision by the qualified professional; codes 97032©–97039© (electrical stimulation, contrast bath therapy, ultrasound therapy, hydrotherapy, and physical therapy treatment unlisted) require direct (one-on-one) contact with the patient by the qualified professional.
- Therapeutic exercise and activities are essential for rehabilitation. The use of modalities as stand-alone treatment is not indicated as a sole approach to rehabilitation. Therefore, an overall course of rehabilitative treatment is expected to consist predominantly of therapeutic procedures (such as codes 97110© (therapeutic exercises), 97112© (neuromuscular re-education), 97116© (gait training therapy) and/or 97530© (therapeutic activities)), with adjunctive use of modalities. Although passive modalities may play a larger role in the early stages of rehabilitation and in treating exacerbations it is expected that modalities will comprise a small portion of the total therapy service time involved during the course of rehabilitative therapy. Further, it is expected that the record will demonstrate both the patient’s clinical progress and concomitant appropriate increasingly active therapeutic treatment.
- When modality codes 97012© (mechanical traction) and 97018© (paraffin bath therapy) are used alone (absent therapeutic procedures and not as a precursor to active treatment) and solely to promote healing, relieve muscle spasm, reduce inflammation and edema, or as analgesia, a limited number of visits (e.g., 1–2) visits may be medically necessary to determine the effectiveness of treatment and for patient education. It is usually not medically reasonable and necessary to continue modality-only treatment by the qualified professional.
- Generally, adjunctive use of services billed with modality codes 97012© (mechanical traction) and 97018© (paraffin bath therapy) is coverable only if they enhance the therapeutic procedures. Documentation supporting the medical necessity and clinical justification for the services’ continued use must be made available to Medicare upon request.
- Generally, only one heating modality per day of therapy is reasonable and necessary. Medicare would not expect to see multiple heating modalities billed routinely on the same day. Exceptions could include musculoskeletal pathology/injuries in which both superficial and deep structures are impaired. Documentation containing clinical justification supporting the medical necessity for multiple heating modalities such as codes 97018, 97024, and 97035 on the same day is essential.
- Treatment with infrared therapy (97026©) is non-covered.
- Anodyne therapy (97039©) is non-covered (see “Non-Covered Services – 4Z-18AB” LCD).
- Generally, only one hydrotherapy modality is coverable per day when the sole purpose is to relieve muscle spasm, inflammation or edema. Documentation must be available supporting the use of multiple modalities as contributing to the patient’s progress and restoration of function. Because some of the modalities are considered components of other modalities and procedures they are not separately reimbursed. Please refer to the Correct Coding Initiative.
- Medicare does not provide payment for the therapeutic modality described as iontophoresis.
- Medicare does not provide payment for the therapeutic modality described as phonophoresis.

Specific Modality Guidelines

The following clinical guidelines pertain to the specific modalities listed. Please refer to the “ICD-9-CM Codes That Support Medical Necessity” section of this policy for appropriate covered diagnoses to be used with these modalities.
G0283 – This modality includes the following types of electrical stimulation:
- Transcutaneous Electrical Nerve Stimulation (TENS).
- Microamperage E-Stimulation (MENS).
- Percutaneous Electrical Nerve Stimulation (PENS).
- Electrogalvanic stimulation (high voltage pulsed current).
- Functional electrical stimulation.
- Interferential current/medium current.

These types of electrical stimulation may be necessary during the initial phase of treatment, but there must be an expectation of improvement in function. Electrical stimulation must be utilized with appropriate therapeutic procedures (e.g., 97110) to effect continued improvement.

Electrical stimulation is typically used in conjunction with therapeutic exercises. It is expected this modality will be used in a clearly adjunctive role and not as a major component of the therapeutic encounter.

When electrical stimulation is used for muscle strengthening or retraining, the nerve supply to the muscle must be intact. It is not medically necessary for completely denervated motor nerve disorders in which there is no potential for recovery or restoration of function.

97012 © (mechanical traction) – This modality, when provided by physicians or independent PTs, is typically used in conjunction with therapeutic procedures, not as an isolated treatment; however, it may be used in weaning an acute patient to a self-administered home program.

97016 © (vasopneumatic device therapy) – Education for the home use of a lymphedema pump is sometimes provided by the lymphedema pump supplier. If the supplier does not provide this education, limited therapy professional visits for such purposes are allowable. Medicare does not expect to be routinely billed for repeated lymphedema treatments. Medicare expects that documentation in the physician’s medical record must support the necessity of repeated services.

For requirements on lymphedema therapy, see TrailBlazer’s LCD “Complex Decongestive Physiotherapy (CDP) for Lymphedema – 4Y-17.”

97018 © (paraffin bath therapy) – Also known as hot wax treatment, this modality may be medically necessary as an adjunct to other physical/occupational therapy interventions but this service is primarily used for pain relief in chronic joint problems of the wrists, hands or feet. Most patients will be capable of self managing these treatments after education. Therefore, when not used as an adjunct to other physical/occupational therapy interventions, Medicare payment for these services will usually be limited to two or three visits. Documentation supporting the medical necessity for repetitive treatments must be made available to Medicare upon request.

97022 © (whirlpool therapy) and 97036 © (hydrotherapy) – These modalities involve the use of agitated water to relieve muscle spasms, improve circulation or cleanse wounds (e.g., ulcers, exfoliative skin conditions).
- Physician or therapist supervision of the whirlpool modality must be medically necessary for the following indications:
  - The patient’s condition is complicated by:
    - Circulatory deficiency.
    - Areas of desensitization.
    - Impaired mobility or limitations in the positioning of the patient.
    - Concerns about safety, if left unsupervised.
- Documentation supporting the medical necessity for additional sessions must be made available to Medicare upon request.
- It is not medically necessary to have more than one form of hydrotherapy during a treatment session.

97028 © (ultraviolet therapy) – Ultraviolet must be prescribed by the attending physician. Minimal erythema dosage must be documented and made available to Medicare upon request.

97032 © (electrical stimulation) – See procedure code G0283 for clinical guidelines for this procedure.

97034 © (contrast bath therapy) and 97035 © (ultrasound therapy) – These modalities are generally used as adjuncts to a therapeutic procedure.

97039 – For all claims submitted with an unlisted modality code, a complete narrative description (detailing the service or procedure being performed) must be included on the claim. This code applies only to a procedure in which constant attendance was a requisite. See TrailBlazer’s LCD, “Non-Covered Services – 4Z-18AB,” for non-covered services billed with CPT code 97039.

General Guidelines for Therapeutic Procedures 97110–97546
- Therapeutic procedures are procedures that attempt to reduce impairment and improve function through the application of clinical skills and/or services.
• Use of these procedures requires that the practitioner have direct (one-on-one) patient contact.
• Codes 97110© (therapeutic exercises), 97112© (neuromuscular re-education), 97113© (aquatic therapy/exercises) and 97530© (therapeutic activities) describe several different types of therapeutic interventions. The expected goals documented in the treatment plan, affected by the use of each of these procedures, will help define whether these procedures are reasonable and medically necessary. Therefore, since any one or a combination of more than one of codes 97110© (therapeutic exercises), 97112© (neuromuscular re-education), 97113© (aquatic therapy/exercises) and 97530© (therapeutic activities) may be used in a treatment plan, documentation must support the use of each code as it relates to specific therapeutic goal(s).
• Documentation supporting the medical necessity for continued treatment must be made available to Medicare upon request.

**Specific Guidelines for Therapeutic Procedures**

The following clinical guidelines pertain to the specific listed therapeutic procedures. Please refer to the “ICD-9-CM Codes That Support Medical Necessity” section of this policy for appropriate covered diagnoses to use for these therapeutic procedures.

**Per Change Request 2083**

In accordance with established conditions, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare physician and implemented by approved Medicare qualified professionals (PTs or OTs) or as "incident to" physician services. Some of the following rehabilitation programs/services for beneficiaries with vision impairment may include Medicare covered therapeutic services.

• Mobility.
• Activities of daily living.
• Other medically necessary services, including low-vision services.

The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning – is not covered. For example, a person with an ICD-9-CM diagnosis of 369.08 (profound impairment in both eyes, i.e., best corrected visual acuity is less than 20/400 or visual field is 10 degrees or less) would generally be eligible for, and may be provided, rehabilitation services under CPT/HCPCS code 97535© (self-care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).

**97110© (therapeutic exercises)** – Therapeutic exercise to develop strength and endurance, range of motion, and flexibility: active, active-assisted or passive (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening). The exercise may be reasonable and medically necessary for a loss or restriction of joint motion, strength, functional capacity or mobility that has resulted from a specific disease or injury. Documentation must show objective loss of joint motion, strength or mobility (e.g., degrees of motion, strength grades, levels of assistance). This therapeutic procedure is measured in 15-minute units with therapy sessions frequently consisting of several units.

**97112© (neuromuscular re-education)** – This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation, Feldenkrais, Bobath, BAP’s boards and desensitization techniques). The procedure may be reasonable and medically necessary for impairments that affect the body’s neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity).

**97113© (aquatic therapy)** – This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). The procedure may be reasonable and medically necessary for a loss or restriction of joint motion, strength, mobility or function that has resulted from a specific disease or injury. Documentation must show objective loss of joint motion, strength or mobility (e.g., degrees of motion, strength grades, levels of assistance).

Do not use this code for situations where no exercise is being performed in the water environment (e.g., debridement of ulcers).

When aquatic therapy is provided in a community pool, the provider must rent or lease at least a portion of the pool for the exclusive use of the patients.

Other forms of exercise therapy may be medically necessary in addition to aquatic therapy when the patient cannot perform land-based exercises effectively to treat his condition without first undergoing the aquatic therapy, or when aquatic therapy facilitates progress to land-based exercise or increased function. Documentation...
must be available in the record to support medical necessity.

It is not medically necessary to employ hydrotherapy and aquatic therapy during the same treatment session.

**Note:** Hydrotherapy refers to codes 97022 and 97036.

97116© (gait training therapy) – This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

This procedure is not reasonable and necessary or medically necessary when the patient's walking ability is not expected to improve.

Repetitive walk-strengthening exercises for feeble or unstable patients or to increase endurance do not require qualified professional supervision and will be denied as not reasonable and necessary.

Generally, CPT code 97116© (gait training therapy) should not be reported with 97760© (orthotic management and training). However, if a service represented by code 97760© (orthotic management and training) was performed on an upper extremity and a service represented by code 97116© (gait training) was also performed, both codes may be billed with modifier 59 to denote separate anatomic sites.

97124© (massage therapy) – This procedure may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to restore muscle function, reduce edema, improve joint motion or for relief of muscle spasm. For manipulation of chest wall (94667), see TrailBlazer's LCD "Outpatient Pulmonary Rehabilitation – 4Y-20."

In most cases, postural drainage and pulmonary exercises can be carried out safely and effectively by ancillary personnel. If the attending physician determines that for the safe and effective administration of these procedures, the professional skills of a PT are required, coverage may be allowed. Documentation of the severity of the pulmonary condition and referral by the physician must be available.

97139© (physical medicine procedure unlisted) – For all claims submitted with an unlisted procedure code, a complete narrative description (detailing the service or procedure being performed) must be included on the claim.

**For example:** Report phonophoresis with CPT code 97139©. However, because there is no evidence from published, controlled clinical studies demonstrating the efficacy of this modality, phonophoresis will be denied as not proven safe and effective, and therefore is not a covered service.

97140© (manual therapy) – Manual therapy such as mobilization, manipulation, manual traction and manual lymphatic drainage. (Manual lymphatic drainage is addressed in a separate TrailBlazer policy.)

Myofascial Release/Soft Tissue Mobilization

This procedure may be medically necessary for the treatment of restricted motion of soft tissues involving the extremities, neck and/or trunk. Skilled manual techniques (active and/or passive) are applied to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples include:

- Facilitation of fluid exchange.
- Restoration of movement in acutely edematous; muscles.
- Stretching of shortened connective tissue.

This procedure may be medically necessary as an adjunct to other therapeutic procedures such as codes 97110© (therapeutic exercises), 97112© (neuromuscular re-education) or 97530© (therapeutic activities).

**Manipulation**

CPT description for code 97140© (manual therapy) includes manual therapy and techniques such as manipulation, soft tissue mobilization or joint mobilization. Individual techniques should not be separately coded or billed since it is a time-based code. All techniques applied on the same date of service should be totaled into the time calculated for the code. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as those represented by code 97110© (therapeutic exercises), 97112© (neuromuscular re-education) or 97530© (therapeutic activities).

**Joint Mobilization**

This procedure may be medically necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure. CPT description for code 97140© (manual therapy) includes manual therapy and techniques such as manipulation, soft tissue mobilization or joint mobilization. Individual techniques should not be separately coded or billed since it is a time-based code. All techniques applied on the same date of service should be totaled into the time calculated for the code.

Documentation supporting the medical necessity for continued treatment must be made available to Medicare
upon request.

97150 © (group therapeutic procedures) – In the case of group therapy (untimed), Medicare expects that skilled, medically necessary services will be provided as appropriate to each patient’s plan of care. Therefore, group therapy sessions (two or more patients) should be of sufficient length to address the needs of each of the patients in the group. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required. Documentation must identify 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 (patient-specific) plan. The number of persons in the group must also be documented. These records must be made available to Medicare upon request.

97530 © (therapeutic activities) – This procedure involves using 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 qualified professional and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

97532 © (cognitive skills development) – This activity focuses on cognitive skills development to improve attention, memory and problem-solving, with direct one-on-one patient contact by the qualified professional, each 15 minutes.

97533 © (sensory integrative techniques) – This activity focuses on sensory integrative techniques to enhance sensory processing and to promote adaptive responses to environmental demands, with direct one-on-one contact by the qualified professional, each 15 minutes.

97535 © (self care management training) – This procedure is medically necessary only when it requires the professional skills of a qualified professional, is designed to address specific needs of the patient and is part of an active treatment plan directed at a specific goal. The patient or caregiver must have the capacity to learn from instructions. Documentation supporting the medical necessity for continued treatment must be made available to Medicare upon request.

Services provided concurrently by physicians, PTs and OTs may be covered if separate and distinct goals are documented in the treatment plans, and an integrated treatment plan is maintained by the requesting physician. Documentation must relate the training to expected functional goals the patient can attain.

97537 © (community/work reintegration training) – This training may be medically necessary when performed in conjunction with a patient’s individual treatment plan aimed at improving or restoring specific functions that were impaired by an identified illness or injury, and when expected outcomes that are attainable by the patient are specified in the plan. This training is medically necessary only when it requires the professional skills of a qualified professional. Generally speaking, the professional skills of a qualified professional are not required to effect improvement or restoration of function when a patient suffers a temporary loss or reduction of function that could reasonably be expected to improve as the patient gradually resumes normal activities. General activity programs and all activities that are primarily social or diversional in nature will be denied because the professional skills of a qualified professional are not required.

Services that 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.

97542 © (wheelchair management training) – This procedure is medically necessary only when it requires the professional skills of a qualified professional, is designed to address specific needs of the patient and is part of an active treatment plan directed at a specific goal. The patient or caregiver must have the capacity to learn from instructions. Documentation of medical necessity must be available on request for an unusual frequency or duration of training sessions. Typically, up to four sessions within one month is sufficient. When billing code 97542 for wheelchair propulsion training, documentation must relate the training to expected functional goals the patient can attain.

97545 © (work hardening) and 97546 © (work hardening add-on) – These services are related solely to
specific work skills and will be denied as not medically necessary for the diagnosis or treatment of an illness or injury.

97750 © (physical performance test) – This testing may be medically necessary for patients with neurological or musculoskeletal conditions when such tests are needed to formulate or evaluate a specific treatment plan or to determine a patient’s capacity.

The patient’s medical record must document the problem requiring tests, the specific tests performed and a measurement report.

Documentation must be submitted with the claim identifying the need for more than 30 minutes of time.

97755 © (assistive technology assessment) – Assistive technology assessment to restore, augment or compensate for existing function or optimize functional tasks requires direct one-on-one contact with the qualified professional, and a written report, each 15 minutes.

97760 © (orthotic management and training) – The medical record should document the distinct treatments rendered when orthotic training for a lower extremity is performed during the same treatment session as gait training (97116) or self-care/home management training (97535). It is unusual to require more than 30 minutes of static orthotics training. In some cases, dynamic training may require additional time.

Documentation supporting the medical necessity for additional time must be made available to Medicare upon request.

Generally, CPT code 97116 should not be reported with 97760. However, if a service represented by code 97760 was performed on an upper extremity and a service represented by code 97116 © (gait training) was also performed, both codes may be billed with modifier 59 to denote separate anatomic sites.

97761 © (prosthetic training) – The medical record should document the distinct goal(s) and service(s) rendered when prosthetic training for a lower extremity is performed during the same treatment session as gait training (97116) or self-care/home-management training (97535).

It is unusual to require more than 30 minutes of prosthetic training per day. Documentation supporting the medical necessity for additional time must be made available to Medicare upon request.

97762 © (check-out for orthotic use) – These assessments may be medically necessary when a device is newly issued or there is a modification or reissue of the device.

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

Documentation must be submitted with the claim identifying the need for more than 30 minutes of time.

97799 – For all claims submitted with an unlisted procedure code, a complete narrative description (detailing the service or procedure being performed) must be included on the claim. See TrailBlazer’s LCD, “Non-Covered Services – 4Z-18AB,” for non-covered services billed with CPT code 97799.

97001–97004 (PT and OT evaluations) – These services are separately billable under one of the three different types of practitioners referenced in the “Description” section of this policy. However, physicians may not report any of these codes in conjunction with an evaluation and management code performed on the same day.

For requirements on cardiac rehabilitation (CPT codes 93797 and 93798), see TrailBlazer’s LCD “Cardiac Rehabilitation – 4C-62.”

95992 – If canalith repositioning is performed by therapy personnel under a therapy plan of care, Medicare expects a physical therapist to perform the service.

Notice: This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

As published in CMS IOM 100-08, Section 13.5.1, to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contract determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the clinical trials NCD are considered reasonable and necessary).
• Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  o Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  o Furnished in a setting appropriate to the patient's medical needs and condition.
  o Ordered and furnished by qualified personnel.
  o One that meets, but does not exceed, the patient's medical need.
  o At least as beneficial as an existing and available medically appropriate alternative.

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.


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.

Note: TrailBlazer has identified the Bill Type and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes. Providers are encouraged to refer to the CMS Internet-Only Manual (IOM) Pub. 100-04, Claims Processing Manual, for further guidance.

042X, 043X, 044X

CPT/HCPCS Codes

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

G0283 Electric stimulation other than wound

95992 © Canalith repositioning proc

97001 © Pt evaluation

97002 © Pt re-evaluation

97003 © Ot evaluation

97004 © Ot re-evaluation

97012 © Mechanical traction therapy

97016 © Vasopneumatic device therapy

97018 © Paraffin bath therapy

97022 © Whirlpool therapy

97024 © Diathermy treatment

97028 © Ultraviolet therapy

97032 © Electrical stimulation

97034 © Contrast bath therapy

97035 © Ultrasound therapy

97036 © Hydrotherapy
97039© Physical therapy treatment
97110© Therapeutic exercises
97112© Neuromuscular re-education
97113© Aquatic therapy/exercises
97116© Gait training therapy
97124© Massage therapy
97139© Physical medicine procedure
97140© Manual therapy
97150© Group therapeutic procedures
97530© Therapeutic activities
97532© Cognitive skills development
97533© Sensory integrative techniques
97535© Self care management training
97537© Community/work reintegration training
97542© Wheelchair management training
97545© Work hardening
97546© Work hardening add-on
97750© Physical performance test
97755© Assistive technology assess
97760© Orthotic mgmt and training
97761© Prosthetic training
97762© C/o for orthotic/prosth use
97799© Physical medicine procedure

**ICD-9-CM Codes That Support Medical Necessity**

See attached ICD-9 CM Coding List for description of "procedure to diagnosis" editing associated with this LCD.

(Extra: 4Y-26AB-R8)

**Limited Coverage Archive:**

<table>
<thead>
<tr>
<th>4Y-26AB-R7</th>
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<th>4Y-26AB-R3</th>
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</tbody>
</table>

See Precursor 4Y-22AB LCD for limited coverage: Physical Medicine and Rehabilitation, Outpatient – 4Y-22AB-R8

**Note:** Limited coverage for CPT codes 97001, 97002, 97003, 97004, 97016, 97139, 97150, 97532, 97533 and 97755 is not being established at this time.

**Note:** Refer to TrailBlazer’s LCD, "Non-Covered Services – 4Z-18AB," for non-covered services billed with CPT codes 97039 and/or 97799.

**Diagnoses That Support Medical Necessity**

N/A

**ICD-9-CM Codes That DO NOT Support Medical Necessity**

N/A

**Diagnoses That DO NOT Support Medical Necessity**

All diagnoses not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this LCD.
Documentation Requirements

- Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and made available to Medicare upon request. This documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.
- Documentation should establish through objective measurements that the patient is making progress toward goals. Results of one of the following four measurements are recommended:
  - 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.

Note: If results of one of the four instruments listed above are not recorded, the medical record shall contain that information outlined in Pub.100-02, Chapter 15, Section 220.3.C.
- The medical record must identify the physician responsible for the general medical care.
- Therapy services must be furnished according to a written treatment plan determined by the physician or by the therapist who will provide the treatment after an appropriate assessment of the condition (illness or injury). All qualified professionals rendering therapy must document the appropriate history, examination, diagnosis, functional assessment, type of treatment, the body areas to be treated, the date therapy was initiated, and expected frequency and number of treatments.
- Outpatient therapy MUST be under the care of a Physician/NPP. An order (sometimes called a referral) for therapy service, documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.
- Certification is the physician's/NPP’s 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. A certification is timely when it is obtained within 30 calendar days of the initial treatment under that plan of care.
- Recertifications must be obtained within the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.
- For CMS recommendations regarding progress reports and modifications to the plan of care, refer to the Medicare Benefit Policy Manual. Pub. 100-02, Chapter 15.
- When a verbal order is used to certify the plan of care a dated notation should be made in the patient's medical record.
- Evidence considered necessary to justify delayed certification should be maintained by the supplier of services.
- Signature and professional identity of the person who established the plan and the date it was established must be recorded with the plan.
- Documentation should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time or the need to establish a safe and effective maintenance program. Evaluation, re-evaluation and assessment documented in Progress Notes should describe objective measurements that, when compared, show improvement in function or decrease in severity or rationalization for an optimistic outlook to justify continued treatment.
- When both a modality/procedure and an evaluation service are billed, the evaluation may be reimbursed if the medical necessity for the evaluation is clearly documented. Allowed unit limitations (once per provider, per discipline, per date of service, per patient) by discipline for CPT codes included in this LCD are described in the “Utilization Guidelines” section below.
- When therapy services are billed as incident to a physician/NPP services, the requirement for direct supervision by the physician/NPP and other “incident to” requirements must be met, even though the service is provided by a licensed therapist who may perform the services unsupervised in other settings.
- Documentation supporting the medical necessity for multiple heating modalities (codes 97018, 97024, 97034) on the same date of service must be available for review and show that all were needed toward the restoration of function.
- A dated notation of a verbal order to certify the plan of care should be made in the patient's medical record.
- Evidence considered necessary to justify delayed certification should be maintained by the supplier of services.
- Signature and professional identity of the person who established the plan and the date it was established must be recorded with the plan.
- The total number of timed minutes must be documented in the medical record.

Appendices

N/A

Utilization Guidelines

Medicare covers the following number of therapy services without routinely requiring medical review of records to
determine medical necessity:

- Five (15 minutes each) timed PT services per patient per day.
- Five (15 minutes each) timed OT services per patient per day.
- Sixty (15 minutes each) PT services per patient per month.
- Sixty (15 minutes each) OT services per patient, per month.

Providers of PT/OT services must be aware, however, that any service reported to Medicare, even when reported at a frequency within the following stated covered guidelines, may be denied if done so in association with medical review of the patient’s record that demonstrates no medical necessity for the services. Similarly, services in addition to the above limits may be payable when done so in association with medical review of the patient’s record that demonstrates medical necessity for additional services.

Likewise, providers of PT/OT services must understand that although Medicare will allow the following units of service, each service must be medically reasonable and necessary for the specific patient and his condition. Additionally, Medicare expects that the patient’s medical record will clearly demonstrate that medical necessity. Further, Medicare does not expect that maximum allowable services will be routinely necessary, necessary for multiple-week periods, or necessary for the entirety of the patient’s course of treatment.

Any federally established financial limitations on outpatient therapy services’ coverage and coding rules will apply.

Allowed units outlined in the table below may be billed no more than once per provider, per discipline, per date of service, per patient. The codes allowed zero units in the column for “Allowed Units” may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP). (See CMS Change Request 5253 for additional detail.)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
<th>Timed/ Untimed</th>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
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<tr>
<td>97001©</td>
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<tr>
<td>97004©</td>
<td>Ot re-evaluation</td>
<td>Untimed</td>
<td>0</td>
<td>1</td>
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</tr>
</tbody>
</table>

Notice: This LCD imposes utilization guideline limitations. Despite Medicare’s allowing up to these maximums, each patient’s condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient’s medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

Sources of Information and Basis for Decision

Medicare National Coverage Determinations Manual – Pub. 100-03, Chapter 1, Part 4, Section 270.6.

J4 (CO, NM, OK, TX) MAC Consolidation


Full disclosure of the sources of information is found with original contractor LCD.

Other Contractor Local Coverage Determinations


“Physical Medicine and Rehabilitation,” Arkansas BlueCross BlueShield (Pinnacle) LCD, (OK, NM) L19574 and L19573.

Advisory Committee Meeting Notes

This LCD does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this LCD was developed in cooperation with advisory groups, which include representatives from physical medicine.
**Advisory Committee meeting dates:**
Revision (October 2009 CACs):
TX 10/14/2009
CO 10/08/2009
NM 10/29/2009
OK 10/21/2009

**Start Date of Comment Period**
Revision (October 2009 CAC): 10/30/2009

**Ending Date of Comment Period**
Revision (October 2009 CAC): 12/14/2009

**Start Date of Notice Period**
04/01/2010

**Revision History**

<table>
<thead>
<tr>
<th>Number</th>
<th>Date</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| R8     | 01/01/2011 | Per administrative decision, CPT code 95992 added to the CPT/HCPCS Codes list; limited coverage for CPT code 95992 added to the “ICD-9-CM Codes that Support Medical Necessity” section; and added description for code 95992 in the “Coding Guidelines” section of related article. Effective date: 01/01/2011.  
  Per CMD decision, text updated under "Utilization Guidelines" section of LCD. Effective date: 05/17/2010. |
| R7     | 01/01/2011 | Per CR 7121 (annual HCPCS update), description changed for the GA modifier in the article. Effective date: 01/01/2011.                           |
  Per provider request, added ICD-9-CM codes 438.20, 438.21 and 438.22 to the limited coverage for CPT/HCPCS codes 97110, 97112, 97116, 97140, 97530 and 97535. Effective date: 11/04/2010. |
| R5     | 05/17/2010 | Edited the description for CPT code 97012 to read mechanical traction instead of manual traction. Effective date: 05/17/2010.                           |
| R4     | 10/18/2010 | Use of LCD and related article made applicable to providers transitioning from WPS to TrailBlazer with addition of Contractor number 04901. Effective date: dates of service on or after 10/18/2010. 
  Per CR 7006 (Annual ICD-9-CM Diagnosis Coding Update), description changed for diagnosis code 724.02 and added code 724.03 to limited coverage for codes 97012, 97022, 97024, 97032, 97036, G0283, 97110, 97112, 97113, 97116, 97134, 97140, 97530, 97535 and 97750. Added diagnosis codes 799.51, 799.52, 799.53 and 799.55 to limited coverage for code 97535. Effective date: 10/01/2010. |
| R3     | 08/13/2010 | Removed ICD-9-CM code 300.11 from limited coverage list for Lists 9, 10 and 15 under the section titled, “ICD-9-CM Codes That Support Medical Necessity.” Correction made due to error since code does not describe the circumstances it was intended to describe. Effective date: 07/27/2010. |
| R2     | 06/07/2010 | Revised text in the LCD section titled, “Indications and Limitations of Coverage and/or Medical Necessity,” to clarify the paragraph regarding the length of a usual treatment session. Effective date: 05/17/2010. |
| R1     | 06/01/2010 | Per provider request, changed title of policy from “Physical Medicine and Rehabilitation, Outpatient” to “Therapy Services (PT, OT, SLP).” Effective date: 5/17/2010. |
Article

Article Title

Therapy Services (PT, OT, SLP) – 4Y-26AB-R8

Contractor's Determination Number

4Y-26AB

Contractor Name

TrailBlazer Health Enterprises

Contractor Number

04001 (04101, 04201, 04301, 04401, 04901).
04002 (04102, 04202, 04302, 04402).

Contractor Type

• MAC – Part A.
• MAC – Part B.

AMA CPT/ADA CDT Copyright Statement

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Primary Geographic Jurisdiction

• CO
• NM
• OK
• TX:
  ○ Indian Health Service.
  ○ End Stage Renal Disease (ESRD) facilities.
  ○ Skilled Nursing Facilities (SNFs).
  ○ Rural Health Clinics (RHCs).
• Transitioned WPS legacy providers.

Oversight Region

• Region IV.
• Region VI.

Original Article Effective Date

05/17/2010

Article Revision Effective Date

01/01/2011

Revision Ending Date

N/A

Article Ending Effective Date

N/A

Article Text

Abstract

The related policy defines the coverage and limitations under Medicare for outpatient Physical Therapy (PT), Occupational Therapy (OT) and Speech-Language Pathology (SLP) services provided by physicians, non-physician practitioners, and/or independent PTs, OTs and SLPs in home and office settings, skilled nursing facilities, home health agencies, clinics, rehabilitation agencies, public health agencies, comprehensive outpatient rehabilitation facilities, and hospices.

Definition of Terms
Qualified Professionals include the following who are licensed or certified by the state to perform therapy services and who also may perform therapy services under Medicare:

- Physicians (MD, DO, OD, DPM) and/or non-physician practitioners (physicians assistant, clinical nurse specialist, nurse practitioner).
- Therapists (PT, OT, SLP).

Providers of services include the following, and the term is used to mean a facility (not a person who provides a service):

- Participating hospitals, Critical Access Hospitals (CAHs), Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Home Health Agencies (HHAs), hospices, participating clinics, rehabilitation agencies or Outpatient Rehabilitation Facilities (ORFs).
- Public health agencies with agreements to furnish outpatient therapy services, community mental health centers with agreements only to furnish partial hospitalization services

**Not Covered**

This term means that a requirement in Medicare’s definition of the benefit category is not met and coverage is denied. No Medicare payment is made.

**Not Medically Necessary**

This term means that, although the benefit category requirements are met, the service is not reasonable and necessary for the diagnosis or treatment of the patient’s condition. Medicare payment is denied unless the provider qualifies for a waiver under limitation on liability provisions.

**Outpatient Rehabilitative Therapy**

Therapy services shall 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 therapist, or in the case of PT and OT by or under the supervision of a therapist.

Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

Outpatient therapy services furnished to a beneficiary by a provider or supplier are payable only when furnished in accordance with certain conditions. The following conditions of coverage apply. The requirements noted (*) are also conditions of payment in 42CFR424.24(c) and, according to the Social Security Act, Section 1835(a)(2)(D), are the three conditions that must be certified:

- Such services are or were required because the individual needed therapy services* (see Section 220.1.3).
- A plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP* (see Section 220.1.2).
- Such services are or were furnished while the individual is or was under the care of a physician* (see Section 220.1.1).
- Services must be furnished on an outpatient basis (see Section 220.1.4).

**Complexities**

Complicating factors that may influence treatment, e.g., they may influence the type, frequency and/or duration of treatment. Complexities may be represented by diagnoses; by patient factors such as age, severity, acuity, multiple conditions and motivation; or by the patient's social circumstances, such as the support of a significant other or the availability of transportation to therapy.

**Incident To**

This term means services that are:

- Furnished as an integral part of a physician’s or non-physician practitioner’s personal professional services and are provided by those trained specifically in PT, OT and/or SLP. Services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low-vision specialists or any other professional may not be billed as therapy services.
- To be considered an employee for purposes of this section, the therapist performing the service may be:
  - Part time.
  - Full time.
  - An independent contractor and/or a leased employee of the supervising physician, physician group practice or the legal entity that employs the physician who provides personal supervision.
  - Furnishing a course of treatment where the physician performs an initial direct, professional service and performs subsequent services at a frequency that reflects his continuing active participation in, and management of, the course of treatment.
- Medicare does not cover services provided "incident to" a therapist or physician/NPP. Although Physical
Therapist Assistants (PTAs) and Occupational Therapist Assistants (OTAs) work under the supervision of a therapist and their services may be billed by the therapist, this is not considered “incident to.” PTA and OTA services are covered under therapy services benefit, not the “incident to” benefit.

**Note:**
- Therapy services (PT, OT and/or SLP) provided “incident to” a physician or non-physician practitioner require direct supervision.
- “Incident to” services do not apply in a hospital setting.

**Direct Supervision in the Office**

This term means that the physician must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing services.

In a physician-directed clinic where responsibility is shared for supervision of medical services performed by employees of the clinic, the physician who orders a service is not necessarily the same physician who provides direct medical supervision while the service is performed.

Regardless of the scope of practice for chiropractors as defined by individual states, Medicare recognizes chiropractors as physicians with respect to specified services. Coverage extends only to treatment by manipulation of the spine to correct a subluxation demonstrated by X-ray. Therefore, chiropractors cannot be considered physicians for the purpose of supervising other services.

**Note:** General supervision (PT or OT is available but not necessarily on the premises) is required for PTAs and/or OTAs in all settings but private practice (of the PT or OT) which requires direct supervision, unless state law is more stringent.

**Qualification Requirements**

**Physician**

A physician is a doctor of medicine, osteopathy (including an osteopathic practitioner) or podiatric medicine. Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

**Non-Physician Practitioners (NPP)**

An NPP is a physician assistant, clinical nurse specialist or nurse practitioner who may, if state and local law permit, and when appropriate rules are followed, provide, certify or supervise therapy services.

**Physical Therapist (PT)**

A qualified PT is a person who is licensed as a physical therapist by the state in which practicing, and who meets one of the following requirements:

- Graduated from a physical therapy curriculum approved by the American Physical Therapy Association (APTA), the Committee on Allied Health Education and Accreditation of the American Medical Association (AMA), or the Council on Medical Education of the AMA and the American Physical Therapy Association (APTA).
- Prior to January 1, 1996 (1) was admitted to membership by the APTA, or (2) was admitted to registration by the American registry of Physical Therapists, or (3) has graduated from a physical therapy curriculum in a four-year college or university approved by a state department of education.
- Has two years of appropriate experience as a PT and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking qualification as a PT after December 31, 1977.
- Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.
- If trained outside the United States, (1) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, (2) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

**Physical Therapist Assistant (PTA)**

A PTA is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and meets one of the following requirements:

- Has graduated from a two-year college-level program approved by the American Physical Therapy Association.
- Has two years of appropriate experience as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that
these determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a PTA after December 31, 1977.

**Note:** The services of PTAs used when providing covered therapy benefits are included as part of the covered service.

**Occupational Therapist (OT)**

A qualified OT for program coverage purposes is an individual who meets one of the following requirements:

- Is a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education of the American Medical Association and the American Occupational Therapy Association.
- Is eligible for the National Registration Examination of the American Occupational Therapy Association.
- Has two years of appropriate experience as an OT and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an OT after December 31, 1977.

**Occupational Therapist Assistant (OTA)**

An OTA is a person who meets one of the following requirements:

- Meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association.
- Has two years of appropriate experience as an occupational therapy assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

**Note:** The services of OTAs used when providing covered therapy benefits are included as part of the covered service.

**Speech-Language Pathologist (SLP)**

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology or audiology) granted by the American Speech-Language Hearing Association.
- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

**Note:** Services of speech-language pathology assistants are not recognized for Medicare coverage.

**Part A Program Instructions:**

**Reasons for Denial**

- For claims submitted by an outpatient hospital, ORF, CORF, SNF (if patient is not in Medicare-certified part of an SNF) or nursing home:
  - Services not performed by or under the direct supervision of the qualified therapist (PT, OT, SLP) are not covered.
  - Claims submitted by anyone other than a therapist enrolled as a Medicare provider are not covered.
  - Services performed by persons who are not employees of the therapist are not covered.
  - Services not relating to a written treatment plan that was established by the therapist or by the physician or non-physician practitioner before treatment began are not covered.
  - Services performed under a written treatment plan that has not been certified by a physician or non-physician practitioner at least every 30 days from the initial encounter (i.e., the day when the evaluation is performed) are not covered.
  - Therapy and/or SLP services that do not require the professional skills of a qualified therapist/pathologist to perform or supervise are not medically necessary.
  - The CORF services benefit does not recognize a non-physician practitioner for orders and certification.
- If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of PT services required to achieve such potential, therapy would not be covered because it is not considered rehabilitative or reasonable and necessary.
- Procedure code 97010 is bundled into the payment for all other services including, but not limited to, office visits and physical therapy. It is never paid separately.
- Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of this as a physical medicine modality, the service represented by code 97033 will be denied as not proven safe and effective.
- Medicare has determined that as a therapy, hot and cold packs are easily self-administered, more commonly
used in the home and generally not covered.  
- Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of microwave therapy, Medicare would not expect to see this billed.
- Heat modalities (codes 97024 and 97035) for the treatment of pulmonary conditions will be non-covered as not medically reasonable and necessary.
- Electrical stimulation (codes 97014 and 97032) is considered not reasonable and necessary for motor nerve disorders such as Bell's palsy.
- Due to the duplication of services represented by the code for manual manipulation, soft tissue mobilization, joint mobilization (code 97140) and the codes for osteopathic manipulation (98925–98929), separate payment will not be allowed if any of these codes are reported for the same patient on the same date of service.
- When physical or occupational therapy or speech-language pathology services are performed for a hospital inpatient by a PT, OT or SLP, the service is not payable under the carrier physician fee schedule. For a physician to be reimbursed for one of these services, the service must be personally performed by the physician. The service is not payable if it is performed under the physician's supervision by auxiliary personnel as "incident to" the physician's service, but instead is bundled into the hospital payment.
- Higher amounts of units are billed than those allowed by Medicare (see "Utilization Guidelines" section of related LCD).
- Services that can be safely and effectively furnished by non-skilled personnel or by PTAs or OTAs without the supervision of therapists. These services are not rehabilitative therapy services.
- Services determined not to be medically necessary when reviewing claims for services excepted from the therapy caps due to identification of a pattern of aberrant billing or during normal pre- and post-payment medical review.
- Conditions not accepted as standards of practice within the physician community or supported by peer-reviewed literature.
- All other indications not listed in the “Indications and Limitations of Coverage” section of the related LCD.
- The service(s) rendered is not consistent with accepted standards of medical practice.
- The medical record does not verify that the service described by the CPT/HCPCS code was provided.
- The service does not follow the guidelines of the related LCD.
- The service is considered:
  - Investigational.
  - For routine screening.
  - A program exclusion.
  - Otherwise not covered.
  - Never medically necessary.

**Coding Guidelines**

- Refer to the Correct Coding Initiative (CCI) for correct coding guidelines and specific applicable code combinations prior to billing Medicare. Provisions of this LCD do not take precedence over CCI edits.
- For claims submitted by a provider for services under arrangement (e.g., PT, OT or SLP):
  - The provider must assume professional responsibility (supervision) for the services much like that required for salaried employees:
    - Accept the patient for treatment in accordance with its admission policies.
    - Maintain clinical record (complete and timely) to include diagnosis, medical history, orders and progress notes.
    - Maintain liaison with the attending physician/non-physician practitioner with regard to patient progress and review of the treatment plan.
    - Obtain from the attending physician/non-physician practitioner necessary certification and re-certifications.
    - Ensure that the medical necessity of such service is reviewed on a sample basis, as required.
    - Furnished in accordance with a written contract.
- Payable rehabilitation services (as per IOM Pub. 100-02, Chapter 15, Section 230): "To be covered PT, OT or SLP services, the services must relate directly and specifically to an active written treatment regimen established by the physician or non-physician practitioner after any needed consultation with the qualified PT, OT or SLP and must be reasonable and necessary to the treatment of the individual's illness or injury. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist or under his supervision. Services which do not require the performance or supervision of a therapist are not considered reasonable or necessary services."
- To report services, use the appropriate HCPCS or CPT code(s).
- When Physical Medicine and Rehabilitation (PM&R) services are performed for patients who have suffered musculoskeletal or neurological complications secondary to some other disease, use the diagnosis reflecting the reason for the encounter, not the underlying condition. For example:
  - When patients have become deconditioned because of prolonged inactivity (as a result of an illness), use ICD-9-CM diagnosis codes such as 728.2, 799.3 or 799.4 and not the diagnosis code for the cardiac condition.
For aftercare of corrective surgery for deformities, use the appropriate “V” codes for surgical aftercare, not the diagnosis codes for the congenital or acquired deformity.

Use the following modifiers when billing outpatient rehabilitation services:

- **GN** – Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care.
- **GO** – Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care.
- **GP** – Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.

When physicians/NPPs bill “always therapy” codes they must follow the policies of the type of therapy they are providing, e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units (see table in the “Utilization Guidelines” section of the related LCD), for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an “always therapy” code unless the service is provided under a therapy plan of care.

When a “sometimes therapy” code is billed by a physician/NPP, but as a medical service and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the table (see “Utilization Guidelines” section of the related LCD) per patient, per provider/supplier, per day.

If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of code 97112 and 23 minutes of code 97110 were furnished, then the total treatment time was 47 minutes; so only three units can be billed for the treatment. The correct coding is two units of code 97112 and one unit of code 97110, assigning more units to the service that took the most time.

**Use CPT code 95992 for canalith repositioning procedures (Epley maneuver, Semont maneuver).**

Include the KX modifier on the claim for medically necessary services that exceed the limitations established by federal law, when authorized. Documentation in the medical record must support the diagnoses or patient factors that influenced the need for the therapy services that exceeded the cap. (Refer to the Medicare Claims Processing Manual, Publication 100-04, Chapter 5, Section 10.2.)

Diagnosis(es) must be present on any claim submitted and coded to the highest level of specificity for that date of service.

To report these services, use the appropriate HCPCS or CPT code(s).

All coverage criteria must be met before Medicare can reimburse this service.

When billing for this service in a non-covered situation (e.g., does not meet indications of the related LCD), use the appropriate modifier (see below). To bill the patient for services that are not covered (investigational/experimental or not reasonable and necessary) will generally require an Advance Beneficiary Notice (ABN) be obtained before the service is rendered.

- **Modifiers:**
  - **GA:** Waiver of liability statement issued as required by payer policy, individual case. (Use for patients who do not meet the covered indications and limitations of this LCD and for whom an ABN is on file.) (ABN does not have to be submitted but must be made available upon request.)
  - **GZ:** Waiver of liability statement is not on file. (Use for patients who do not meet the covered indications and limitations of this LCD and who did not sign an ABN.)

See also Bill Type and Revenue Code sections below.

**Part B Program Instructions:**

**Reasons for Denial**

- For claims submitted by a physician or non-physician practitioner:
  - Services performed by non-employees or those not under a physician’s or non-physician practitioner’s direct supervision are not covered.
  - Services not relating to a written treatment plan are not medically necessary.
  - Services that do not require the professional skills of a physician or non-physician practitioner to perform or supervise are not medically necessary.

- For claims submitted by a PT, OP or SLP in independent practice:
  - An order, sometimes called a referral, for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.
  - Claims submitted by anyone other than a therapist enrolled as a Medicare provider are not covered.
  - Services not performed by or under the direct supervision of the therapist are not covered.
  - Services performed by persons who are not employees of the therapist are not covered.
  - Services not relating to a written treatment plan, established by the therapist or by the physician before treatment began, are not covered. Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same qualified professional who established the plan and that...
Plan is established and signed by close of business on the next day by the same qualified professional.

- Services performed under a treatment plan that has not been certified by a physician at least every 30 days from the initial encounter (i.e., the day when the evaluation is performed) are not covered.
- Services not furnished in the therapist’s office or in the patient’s home are not covered.
- Physical therapy services that do not require the professional skills of a qualified PT to perform or supervise are not medically necessary.
- Occupational therapy services that do not require the professional skills of a qualified OT to perform or supervise are not medically necessary.
- Speech-language pathology services that do not require the professional skills of a qualified SLP to perform or supervise are not medically necessary.

- If an individual’s expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, therapy would not be covered because it is not considered rehabilitative or reasonable and necessary.
- Procedure code 97010 is bundled into the payment for all other services including, but not limited to, office visits and physical therapy. It is never paid separately.
- Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of this as a physical medicine modality, the service represented by code 97033 will be denied as not proven safe and effective.
- Medicare has determined that as a therapy, hot and cold packs are easily self-administered, more commonly used in the home and generally not covered.
- Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of microwave therapy, Medicare would not expect to see this billed.
- Heat modalities (codes 97024 and 97035) for the treatment of pulmonary conditions will be non-covered as not medically reasonable and necessary.
- Electrical stimulation (codes 97014 and 97032) is considered not reasonable and necessary for motor nerve disorders such as Bell’s palsy.
- Due to the duplication of services represented by the code for manual manipulation, soft tissue mobilization, joint mobilization (code 97140) and the codes for osteopathic manipulation (98925–98929), separate payment will not be allowed if any of these codes are reported for the same patient on the same date of service.
- When physical or occupational therapy is performed for a hospital inpatient by a PT or OT, the service is not payable under the carrier physician fee schedule. For a physician to be reimbursed for one of these services, the service must be personally performed by the physician. The service is not payable if it is performed under the physician’s supervision by auxiliary personnel as “incident to” the physician’s service, but instead is bundled into the hospital payment.
- Higher amounts of units are billed than those allowed by Medicare (see “Utilization Guidelines” section of related LCD).
- Services that can be safely and effectively furnished by non-skilled personnel or by PTAs or OTAs without the supervision of therapists. These services are not rehabilitative therapy services.
- Services determined not to be medically necessary when reviewing claims for services excepted from the therapy caps due to identification of a pattern of aberrant billing or during normal pre- and post-payment medical review.
- Conditions not accepted as standards of practice within the physician community or supported by peer-reviewed literature.
- All other indications not listed in the “Indications and Limitations of Coverage” section of the related LCD.
- Service(s) rendered is not consistent with accepted standards of medical practice.
- The medical record does not verify that the service described by the CPT/HCPCS code was provided.
- The service does not follow the guidelines of the related LCD.
- The service is considered:
  - Investigational.
  - For routine screening.
  - A program exclusion.
  - Otherwise not covered.
  - Never medically necessary.

**Coding Guidelines**

- Refer to the Correct Coding Initiative (CCI) for correct coding guidelines and specific applicable code combinations prior to billing Medicare. Provisions of this LCD do not take precedence over CCI edits.
- Physicians, independent PTs and OTs may bill for physical medicine services using the HCPCS physical medicine and rehabilitation codes. Refer to the Correct Coding Initiative (CCI) for specific code(s) that are bundled and not separately payable.
- For claims submitted by a PT, OT or SLP in independent practice, an order, sometimes called a referral, for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.
- Payable rehabilitation services (as per IOM Pub. 100-02, Chapter 15, Section 230): “To be covered PT, OT or
speech-language pathology services, the services must relate directly and specifically to an active written

### Local Coverage Determinations

#### Tools


**Local Coverage Determinations | Tools | TrailBlazerHealth.com - Therapy...**

**Bill Types** indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally

- **Absence of a Bill Type** does not guarantee that the policy does not apply to that Bill Type. Complete absence of all

### 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 indicate that coverage is not influenced by Bill Type and the policy should be assumed to apply equally

#### 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** indicate that coverage is not influenced by Bill Type and the policy should be assumed to apply equally

- **To report services**, use the appropriate HCPCS or CPT code(s).

- **When Physical Medicine and Rehabilitation (PM&R)** services are performed for patients who have suffered

### Musculoskeletal or neurological complications secondary to some other disease, use the diagnosis reflecting the

- **reason for the encounter**, not the underlying condition. For example:

- **ICD-9-CM diagnosis codes** such as 728.2, 799.3 or 799.4 and not the diagnosis code for the cardiac condition.

- **For aftercare of corrective surgery for deformities**, use the appropriate “V” codes for surgical aftercare, not

### the diagnosis codes for the congenital or acquired deformity.

- **Use the ICD-9-CM diagnosis codes for muscle spasm or contractures** when they are the complications of another

### disorder.

- **Use the following modifiers when billing outpatient rehabilitation services**:```

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- **When physicians/NPPs bill “always therapy” codes** they must follow the policies of the type of therapy they are

### providing, e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed

### units (see table in the “Utilization Guidelines” section of the related LCD), for PT, OT or SLP depending on the

### plan. A physician/NPP shall not bill an “always therapy” code unless the service is provided under a therapy plan

### of care.

- **When a “sometimes therapy” code** is billed by a physician/NPP, but as a medical service and not under a therapy

### plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of

### units indicated in the table (see “Utilization Guidelines” section of the related LCD) per patient, per

### provider/supplier, per day.

- **If more than one CPT code is billed during a calendar day**, then the total number of units that can be billed is

### constrained by the total treatment time. For example, if 24 minutes of code 97112 and 23 minutes of code

### 97110 were furnished, then the total treatment time was 47 minutes; so only three units can be billed for the

### treatment. The correct coding is two units of code 97112 and one unit of code 97110, assigning more units to

### the service that took the most time.

- **Use CPT code 95992** for canalith repositioning procedures (Epley maneuver, Semont maneuver).```

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- **Include the KX modifier** on the claim for medically necessary services that exceed the limitations established by

### federal law, when authorized. Documentation in the medical record must support the diagnoses or patient

### factors that influenced the need for the therapy services that exceeded the cap. (Refer to the Medicare Claims

### Processing Manual, Publication 100-04, Chapter 5, Section 10.2.)

- **All coverage criteria** must be met before Medicare can reimburse this service.

- **Diagnosis(es)** must be present on any claim submitted and coded to the highest level of specificity for the dates

### of service.

- **The diagnosis code(s)** must be representative of the patient’s condition.

- **When billing for this service in a non-covered situation** (e.g., does not meet indications of the related LCD), use

### the appropriate modifier (see below). To bill the patient for services that are not covered

### (investigational/experimental or not reasonable and necessary) will generally require an Advance Beneficiary

### Notice (ABN) to be obtained before the service is rendered.

### Modifiers:

- **GA**: Waiver of liability statement issued as required by payer policy, individual case. (Use for patients who do not meet the covered indications and limitations of this LCD and for whom an ABN is on file.) (ABN does not have to be submitted but must be made available upon request.)

- **GZ**: Waiver of liability statement is not on file. (Use for patients who do not meet the covered indications and limitations of this LCD and who did not sign an ABN.)

- **Bill Type and Revenue Codes** below DO NOT apply to Part B.

### 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
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.

Note: TrailBlazer has identified the Bill Type and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes. Providers are encouraged to refer to the CMS Internet-Only Manual Publication 100-04, Claims Processing Manual, for further guidance.

CPT/HCPCS Codes

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

G0283 Electric stimulation other than wound
95992© Canalith repositioning proc
97001© Pt evaluation
97002© Pt re-evaluation
97003© Ot evaluation
97004© Ot re-evaluation
97012© Mechanical traction therapy
97016© Vasopneumatic device therapy
97018© Paraffin bath therapy
97022© Whirlpool therapy
97024© Diathermy treatment
97028© Ultraviolet therapy
97032© Electrical stimulation
97034© Contrast bath therapy
97035© Ultrasound therapy
97036© Hydrotherapy
97039© Physical therapy treatment
97110© Therapeutic exercises
97112© Neuromuscular re-education
97113© Aquatic therapy/exercises
97116© Gait training therapy
97124© Massage therapy
97139© Physical medicine procedure
97140© Manual therapy
97150© Group therapeutic procedures
97530© Therapeutic activities
97532© Cognitive skills development
97533© Sensory integrative techniques
97535© Self care management training
97537© Community/work reintegration training
97542© Wheelchair management training
97545© Work hardening
97546© Work hardening add-on
97750© Physical performance test
97755© Assistive technology assess
97760© Orthotic management and training
97761© Prosthetic training
97762© C/o for orthotic/prosth use
97799© Physical medicine procedure

Other Comments
N/A

Comment Summary

LCD Comment and Notice Summary Report

LCD Title: Therapy Services – 4Y-26AB

LCD Lead: DLP

Comment Topic #1
Commentator Suggestion(s): Develop safety valve mechanism for payment of claims for circumstances that might exceed limited numbers of services propose in draft policy. The comment lists some circumstances believed to potentially fit this category of claims.

Pre- Finalization Recommendation -
Agree with the comment. Have discussed with Part B MR Manager and Coverage Policy staff the possible manners in which this could be accomplished.

Finalization Recommendation -
Finalize with modifications related to comments.

Comment Topic #2
Commentator Suggestion(s): Frequency limits proposed in this LCD constitute a "rule of thumb" limitation that is prohibited by manual instruction (multiple citations from 100-02) and Medicare law.

Pre- Finalization Recommendation -
Three of the manual citations about "rules of thumb" from the AOTA apply to SNF admissions and therapy, inpatient hospital admissions, and Home Health Services. They do not apply to Part B payment to therapists for outpatient therapy or Part A payments to facilities for outpatient therapy.

The fourth manual citation from the PIM, regarding financial limitations for therapy services (a.k.a. therapy caps) when placed in the context of the remainder of that manual section, clearly does not prohibit frequency limitations based on policy especially when the appeal avenue remains available for payment of services to extraordinary patients demonstrated to be medical reasonable and necessary by medical record review.

Finalization Recommendation -
Finalize as written. Continue to work with TPTA to make further refinements in frequency/diagnosis group operationality of this LCD.
Finalization Committee Recommendation
Proceed with finalization of Physical Medicine and Rehabilitation, Outpatient for J4 MAC/ Part B and Part A; with changes as suggested above.

Finalization Misc. Notes: As above.

Additional Information
[No additional information has been specified for this record]

Comments
Comments are closed.

This content pertains to...

Programs: Part A, Part B

Topics: Facility Types, Policies, Special Provider Types, Specialty Services

Subtopics: FQHC, Indian Health, Local Coverage Determinations, OPPS, ORF/CORF, Podiatry, RHC, SNF, Therapy Services