HIGHMARK HEALTH OPTIONS

Medical Policy

Physical Medicine

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Approved By:	Highmark Health Options – Market Leadership
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Page Number(s):	1 of 9

Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

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

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

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

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus members.

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

PROCEDURES

1. A prior authorization is required.

Physical medicine is a covered service when performed with the expectation of restoring the individual's level of function that has been lost or reduced by injury or illness.

Treatment plans must be maintained in the medical record and made available upon request. A typical session usually consists of up to one (1) hour of rehabilitative therapy which could include up to four (4) physical medicine modalities/procedures and/or units performed on the same date of service, per performing provider.

Duplicate therapy is not considered medically necessary.

2. Physical medicine evaluation

   Evaluation and Management (E&M) service is considered an inherent part of a physical medicine evaluation. The E&M service is not eligible for separate payment when reported on the same day as a physical medicine evaluation.

   When an E&M service is reported in conjunction with a physical medicine evaluation the services must be combined under the appropriate code for the physical medicine evaluation.

   Modifier "-25" may be reported with medical care (e.g., E&M visits, consultations) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier "-25" is reported, the individual's medical records must clearly document that separately identifiable medical care was rendered.

   Muscle testing, ROM testing, and physical performance testing are considered components of a physical medicine evaluation and are not eligible for separate payment when billed on the same date of service as a physical medicine evaluation.

   Modifier "-59" may be reported with a non-E&M service, to identify it as distinct or independent from other non-E&M services performed on the same day.

3. Maintenance therapy

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

   A maintenance program consists of activities that preserve the individual's present level of function and prevent regression of that function. These services would not involve complex physical medicine and rehabilitative procedures, nor would they require clinical judgment and skill for safety and effectiveness.

   Maintenance begins when the therapeutic goals of a treatment plan have been achieved, and no additional functional progress is apparent or expected to occur. Maintenance therapy should be reported under procedure code S8990 (physical or manipulative therapy performed for maintenance rather than restoration), and is not eligible for reimbursement.

4. Habilitative therapy

   Habilitative therapy services ordered by a professional provider to promote the restoration, maintenance, or improvement in the level of function following disease, illness or injury. This includes therapies to achieve functions or skills never acquired due to congenital and developmental anomalies.

Habilitative/Rehabilitative therapy services must be reported with the 96 or 97 modifiers in conjunction with the appropriate therapy code.

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

*Spinal manipulation is not considered an habilitative service.

5. Supervised modalities

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

6. Vasopneumatic compression

   Vasopneumatic compression treatment is warranted for the following conditions:

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

   Conditions other than those listed above or indicate that an infection is present will be denied as not medically necessary.

   Vasopneumatic compression service is considered a supervised modality and is not considered time-based. It should be reported only once per treatment session, regardless of the number of areas treated or the length of time required to complete treatment.

   Services provided by devices that provide both vasopneumatic compression and cold therapy simultaneously, should be reported with code 97016.

7. Infrared therapy

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

8. Constant attendance modalities

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

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

9. Aquatic therapy

   Aquatic therapy must be performed with the expectation of restoring an individual's level of function that has been lost or reduced by injury or illness. Aquatic therapy performed to maintain a level of function is considered to be a maintenance program and is not eligible for reimbursement.

A provider must have direct (one to one) contact with the individual when reporting aquatic therapy.

Before beginning an aquatic therapy program, the provider must prepare a treatment plan that includes short-term and long-term goals that the individual can be reasonably expected to accomplish through the aquatic therapy program and the specific methods chosen.

Separate payment will not be made for whirlpool or Hubbard tank in addition to aquatic therapy with therapeutic exercise for a single encounter.

10. Gait training

Accepted indications for gait training include, but are not limited to:

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

Documentation for gait training must demonstrate that the individual's gait was improved either by lengthening the gait or increasing the frequency of cadence lower extremity.

- Procedure code 97116 should not be used to report orthotics or prosthetics training.
- Orthotics training should be reported using procedure codes 97760 and 97763.
- Prosthetics training should be reported using procedure codes 97761 and 97763.

11. Vestibular rehabilitation therapy

A vestibular rehabilitation program typically last 45 minutes per session and is prescribed 1-2 times per week. In general, individuals remain in the program 4-8 weeks.

A vestibular rehabilitation program may be considered medically necessary for individuals with vertigo, disequilibrium, and balance deficits related to the following conditions:

- Peripheral vestibular disorders (e.g., labyrinthitis, neuritis, benign paroxysmal positional vertigo, post vestibular surgical symptoms, and bilateral vestibular loss);
- Mixed peripheral and central vestibular disorders; and
- Central causes of vertigo (e.g., CVA, multiple sclerosis, and mild traumatic brain injury).

If none of these conditions are reported, a vestibular rehabilitation program is considered not medically necessary.

12. Not medically necessary

- Dry hydro massage

Experimental/investigational and, therefore, noncovered, because the safety and effectiveness are not supported by current literature.

- Electromagnetic stimulation.
- Equestrian/hippotherapy.
- Low-intensity pulsed ultrasound (hands-free ultrasound).

- Horizontal therapy.
- Low-level laser therapy (cold laser therapy).
- Phonophoresis.

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

13. Post-payment audit statement

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

14. place of service: inpatient/outpatient

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

CODING REQUIREMENTS

CPT code	Description
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side.
95992	Canalith repositioning procedure(s) (e.g., Epley Maneuver, Semont Maneuver) per day.
97012	Application of a modality to 1 or more areas; traction, mechanical.
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended).
97016	Application of a modality to 1 or more areas; vasopneumatic devices.
97018	Application of a modality to 1 or more areas; paraffin bath.
97022	Application of a modality to 1 or more areas; whirlpool.
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave).
97026	Application of a modality to 1 or more areas; infrared.
97028	Application of a modality to 1 or more areas; ultraviolet.
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes.
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes.
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes.
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes.
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes.
97039	Unlisted modality (specify type and time if constant attendance).

97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility.
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing).
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).
97139	Therapeutic procedure, 1 or more areas, each 15 minutes; unlisted therapeutic procedure (specify).
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.
97150	Therapeutic procedure(s), group (2 or more individuals).
97161	Physical therapy evaluation: low complexity, requiring these components: a history with no personal factors and/or comorbidities that impact the plan of care; an examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; a clinical presentation with stable and/or uncomplicated characteristics; and clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: a history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; an examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; an evolving clinical presentation with changing characteristics; and clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: a history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; an examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; a clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: an examination including a review of history and use of standardized tests and measures is required; and revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity, requiring these components: an occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; an assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of low complexity, which includes an analysis of the occupational

	profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: an occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: an occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: an assessment of changes in patient functional or medical status with revised plan of care; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one on one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact, each 15 minutes.
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in the use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes.
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes.
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.

97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes.
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes.
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s) encounter, each 15 minutes.
97799	Unlisted physical medicine/rehabilitation service or procedure.
S8948	Application of modality (requiring constant provider attendance) to one or more areas; low-level laser, each 15 minutes.

COVERED DIAGNOSIS CODES FOR PROCEDURE CODE 97016

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

COVERED DIAGNOSIS CODES FOR PROCEDURE CODE 97116

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

REIMBURSEMENT

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

Reference

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POLICY UPDATE HISTORY

<Date>	<Event>