LCD - Outpatient Physical and Occupational Therapy Services (L33631)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts
National Government Services,	A and B and HHH	14212 - MAC B	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Inc.	MAC			
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
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LCD Information

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CMS National Coverage Policy

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

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

Title XVIII of the Social Security Act (SSA):
Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Sections 1861(g), 1861(p), 1861(s)(2) and 1862(a)(14) of Title XVIII of the Social Security Act define the services of non-physician practitioners.

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862(a)(20) excludes payment for PT or OT services furnished incident to the physician by personnel that do not meet the qualifications that apply to therapists, except licensing.

Code of Federal Regulations
42 CFR, Sections 410.59 and 410.61 describe outpatient occupational therapy services and the plan of treatment for outpatient rehabilitation services, respectively.

42 CFR, Sections 410.60 and 410.61 describe outpatient physical therapy services and the plan of treatment for outpatient rehabilitation services, respectively.

42 CFR, Sections 410.74, 410.75, 410.76, and 419.22 define the services of non-physician practitioners.

42 CFR, Sections 424.24 and 424.27 describe therapy certification and plan requirements.

42 CFR, Sections 424.4, 482.56, 484 and 485.705 define therapy personnel qualification requirements.

42 CFR, Section 486 describes coverage for services rendered by physical therapists in independent practice.

Federal Register
Federal Register, Vol. 72, No. 227, November 27, 2007, pages 66328-66333 and 66397-66408, and the correction notice for this rule, published in the Federal Register on January 15, 2008, pages 2431-2433, addresses personnel qualification standards for therapy services and certification requirements.

Federal Register, July 22, 2002, Decision Memo for Neuromuscular Electrical Stimulation (NMES) for Spinal Cord

Injury (CAG 00153R), at:
http://www.cms.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=55&

CMS Publications:
CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

220 through 230 Coverage and documentation requirements for physical and occupational therapy services.

CMS Publication 100-03, *Medicare National Coverage Decisions (NCD) Manual*, (multiple sections):

provides coverage information on several specific types of therapy services. See body of LCD for individual references.

CMS Publication 100-04, *Claims Processing Manual*, Chapter 5:

10.2 Financial limitation for therapy services (therapy cap).

CMS Publication 100-04, *Claims Processing Manual*, Chapter 5:

20-100 HCPCS coding and therapy billing requirements.

CMS Publication 100-04, *Claims Processing Manual*, Chapter 20:

1-10 Orthotics billing.

CMS, "11 Part B Billing Scenarios for PTs and OTs",
http://www.cms.hhs.gov/TherapyServices/02_billing_scenarios.asp#TopOfPage

Communication from CMS that the Contractor LCD is not required to include the V57.1-V57.89 ICD-9-CM codes.

CMS Transmittal No. 4149, Publication 100-04, *Medicare Claims Processing Manual*, October 23, 2018, removes Functional Reporting requirements and edits for outpatient therapy services.

CMS Transmittal No. 179, Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius, Change request #8458, January 14, 2014, provides clarification that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care."

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Medical Necessity

To be considered reasonable and necessary, the services must meet Medicare guidelines. The guidelines for coverage of outpatient therapies have basic requirements in common.

In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time. Refer to CMS Publication 100-02, *Medicare Benefit Policy Manual*, chapter 15, section 220.2(C).

For example, therapy may not be covered for a fully functional patient who developed temporary weakness from a brief period of bed rest following abdominal surgery. It is reasonably expected that as discomfort reduces and the patient gradually resumes daily activities, function will return without skilled therapy intervention.

A therapy plan of care is developed either by the physician/NPP, or by the physical therapist who will provide the physical therapy services, or the occupational therapist who will provide the occupational therapy services, (only a physician may develop the plan of care in a CORF). The plan must be certified by a physician/NPP.

- If the goal of the plan of care is to improve functioning, the documentation must establish that the patient needs the unique skills of a therapist to improve functioning.
- If the goal of the plan of care is to maintain, prevent or slow further deterioration of functional status function or prevent deterioration, the documentation must establish that the patient needs the unique skills of a therapist to maintain, prevent or slow further deterioration of functional status.

All services provided are to be specific and effective treatments for the patient's condition according to accepted standards of medical practice; and the amount, frequency, and duration of the services must be reasonable.

Services related to recreational activities such as golf, tennis, running, etc., are not covered as therapy services.

The services that are provided must meet the description of skilled therapy below.

Skilled Therapy

Services that do not require the professional skills of a therapist to perform or supervise are not medically necessary, even if they are performed or supervised by a therapist, physician or NPP. The skills of a therapist may also be furnished by an appropriately trained and experienced physician or NPP, or by an assistant (PTA, OTA) appropriately supervised by a therapist. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self management program, restorative nursing program or caregiver assisted program, payment cannot be made for therapy services.

Consider the following when determining if a service is skilled.

The 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 only be safely and effectively performed by a qualified clinician, or therapists supervising assistants.

Maintenance therapy occurs when the skills of a therapist (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service, whose goal is to maintain functional status or to prevent or slow further deterioration in functional status.

- If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered.
- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered.
- If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.
- Such skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the therapy procedures required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or (b) the particular patient's special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient's current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures.
- If at any point in the treatment it is determined that the treatment becomes repetitive and does not require the unique skills of a therapist, the services are non-covered.
- There may be circumstances where the patient, with or without the assistance of an aide or other caregiver, does activities planned by a clinician. Although these activities may be supportive to the patient's treatment, if they can be done by the patient, aides or other caregivers without the active participation of qualified professional/auxiliary personnel, they are considered unskilled.
- An individualized plan of exercise and activity for patients and their caregiver(s) may be developed by clinicians to maintain and enhance a patient's progress during the course of skilled therapy, as well as after discharge from therapy services. Such programs are an integral part of therapy from the start of care and should be updated and modified as the patient progresses.
- If a patient's limited ability to comprehend instructions, follow directions, or remember skills that are necessary to achieve an increase in function, is so severe as to make functional improvement very unlikely, rehabilitative therapy is not required, and therefore, is not covered. However, limited services in these circumstances may be covered with supportive documentation, if the skills of a therapist are required to establish and teach a caregiver a safety or maintenance program.
    - This does not apply to the limited situations where rehabilitative therapy is reasonable and achieving meaningful goals is appropriate, even when a patient does not have the ability to comprehend instructions, follow directions or remember skills. Examples include sitting and standing balance activities that help a patient recover the ability to sit upright in a seat or wheel-chair, or safely transfer from the wheelchair to a toilet.
    - This also does not apply to those patients who have the potential to recover abilities to remember or follow directions, and treatment may be aimed at rehabilitating these abilities, such as following a traumatic brain injury.
- The use of therapy equipment such as therapeutic pools or gym machines alone does not necessarily make the treatment skilled.
- Medicare does not cover packaged or predetermined therapy services or programs, such as Back Schools or pre-operative joint classes with preset educational activities and exercises for all participants involved. Services must be individualized, medically necessary and require the unique skills of a therapist. (Packaged or predetermined therapy services do not apply to post-surgical protocols that provide ranges and guidance.)

Personnel Authorized to Provide Outpatient Therapy Services

Medicare billable therapy services may be provided by any of the following within their scope of practice and consistent with state and local law:

- physician;
- non-physician practitioner (NPP) (physician assistants, nurse practitioners, clinical nurse specialists);
- qualified physical and occupational therapists, speech language pathologists*, and assistants working under

the supervision of a qualified therapist;
- qualified personnel, with or without a license to practice therapy, who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP.

*Please refer to the LCD for Speech Language Pathology (L33580) for further coverage information on speech language pathology services.

Personnel NOT Authorized to Provide Outpatient Therapy Services
Students*, aides, athletic trainers, exercise physiologists, massage therapists, recreation therapists, kinesiotherapists, low vision specialists, lymphedema specialists, pilates instructors, rehabilitation technicians and life skills trainers are not considered qualified therapy professionals and may not bill their services under the Medicare therapy benefit, even if performed under the supervision of a qualified therapist.

*See Therapy Students section in the related Billing and Coding article for further clarification regarding student participation in treatment.

CMS established the qualifications to assure that all personnel who provide therapy services are suitably trained in the discipline they practice. Personnel who do not meet the applicable professional standards to be considered qualified professional/personnel cannot furnish or be paid for physical or occupational therapy services.

Private Practice Therapy Services
All therapy medical necessity, certification, documentation and coding guidelines of this LCD apply to all outpatient settings, including therapy services provided by private practitioners. In addition, in the private practice setting, all services not performed by the therapist must be performed by an assistant who is an employee of the practice and must be under direct supervision of the therapist.

Therapy Provided by Physicians and Physician Employees

Physical and occupational therapy services may be provided by physicians, non-physician practitioners (NPPs), or incident-to the services of physicians/NPPs when provided by physical or occupational therapists, in the office or home. All therapy medical necessity, certification, documentation, and coding guidelines of this LCD apply with one exception. When therapy services are performed incident-to a physician's/NPP's service, the *therapist* does not need a license to practice therapy, unless it is required by state law. All other physical or occupational therapist qualifications (education and training) must be met. Therapy services must be directly supervised.

Indications and Limitations of Coverage and/or Medical Necessity for specific modalities and procedures:

Therapy services should be provided in a manner that meets the patient's needs. The treatment plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources. This LCD provides recommendations intended to assist qualified professionals/auxiliary personnel in documenting to support both the medical necessity and the skilled nature of the therapy services provided. In addition, any numerical guidelines related to individual codes in this section of the LCD, are based on contractor medical review experience. These are provided to remind qualified professionals/auxiliary personnel of the importance of justifying therapy services in the documentation as the patient progresses through an episode of care. Documentation must be sufficient to demonstrate the specifics of the therapy provided so that it may be determined that the treatment was medically necessary. Please refer to CMS publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, section 220.3 for the Medicare minimal documentation requirements for therapy services.

Physical therapy evaluation

Occupational therapy evaluation
The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient/caregiver self-reporting. Initial evaluations must be completed by the therapist or physician/NPP that will be providing the therapy services. Initial evaluations are completed to determine the medical necessity of initiating rehabilitative therapy or skilled instruction in maintenance activities that the patient and/or caregiver can perform at home.

Initial evaluation may be warranted when there is a change in functional ability. The evaluation should clearly describe the presenting complaint or problem for which the patient is seeking services of the physical or occupational therapist.

The evaluation process assesses, for example, the severity and impact of the current problem, the possibility of multi-site or multi-system involvement, the presence of pre-existing systemic conditions (e.g., diseases), and the stability of the condition. If the patient presents with multi-system involvement and/or multiple site involvement, all pertinent areas/conditions should be assessed at the initial evaluation (i.e., cervical pain and knee pain; low back pain and rotator cuff irritation; cervical pain and low back pain). Only one initial evaluation code should be used, reflecting the level of complexity of the evaluation, and all presenting complaints and problems evaluated. If over the course of an episode of treatment, a new, unrelated diagnosis occurs, another initial evaluation may be covered.

Initial evaluations may be covered when the documentation justifies the need for a skilled therapy evaluation, even if it is determined that the patient does not require a skilled level of treatment.

Screening may be more appropriate than evaluation in some circumstances. For example, a patient develops an acute lateral epicondylitis from painting. The patient seeks physician attention who subsequently recommends that the patient see an occupational therapist. By the time the patient sees the OT, she presents without any pain and has resumed all normal functional activities. Completing a screening interview of this patient should lead the therapist to determine that an OT evaluation and treatment would not be medically necessary.

- A screening is the gathering of information to determine the need for further evaluation by the clinician. The screening process may include a review of the patient's medical record, a patient interview and observation of the patient.
- Routine screening is not a billable service. Although some regulations and state practice acts require screening evaluations at specific intervals (such as at admission to a nursing home, or quarterly during the patient's stay), for Medicare payment, evaluations must meet Medicare coverage guidelines.

Initial evaluations from other therapy disciplines performed on the same beneficiary may also be covered, provided the evaluation and plan of care are not duplicative.

Consider the following points when billing for an evaluation.

- Evaluations for deconditioning after hospitalization where it is anticipated that prior functional abilities would spontaneously return through patient, caregiver and/or nursing activities are not considered medically necessary and are not covered.
- Pre-operative evaluations performed routinely to ascertain the patient's post-surgical needs and/or to explain the services that will be provided post-operatively are non-covered. The patient's post-op experience and functional limitations are unknown prior to the surgery and will at that time require a new evaluation of the situation when medically necessary.
- Driving assessments provided under an occupational therapy plan of care are covered only when there is a reasonable expectation that the patient's ability to drive will be restored or improved. The need for the assessment must be related to the presence of, or recovery from, a specific injury or illness. Generalized

aging, weakness or debility do not qualify as Medicare covered conditions for assessment or therapy services. Assessment for the sole purpose of disqualifying a patient from driving is not a covered benefit.

Physical therapy reevaluation
Occupational therapy reevaluation
Reevaluation provides additional objective information not included in other documentation, such as treatment or progress notes.

Reevaluations are distinct from therapy assessments. Assessments are considered a routine aspect of intervention and are not billed separately from the intervention. For example, a patient is being seen in physical or occupational therapy for shoulder pain and limited shoulder functional range of motion due to capsular tightness. Prior to performing shoulder joint mobilizations, the therapist assesses the patient's ROM and pain level/pattern to determine the effect of prior treatment and, if further mobilization is warranted, to determine the appropriate mobilizations. After the mobilizations are completed, the ROM is assessed again to determine the effects of the treatment just performed. The time required to assess the patient before and after the intervention is added to the minutes of the treatment intervention.

Consider the following points when billing for a reevaluation.

- When reevaluations are done for a significant change in condition, documentation must show a significant improvement, decline or change in the patient's diagnosis, condition or functional status that was not anticipated in the current plan of care. When a patient exhibits a demonstrable change in functional ability, a reevaluation may be necessary to revise long term goals and interventions. The plan of care may need to be revised and recertified if significant changes are made, such as a change in the long-term goals.
- If a patient is hospitalized during the therapy interval, a reevaluation may be medically necessary if there has been a significant change in the patient's condition which has caused a change in function, long term goals, and/or treatment plan.
- Reevaluations may be appropriate at a planned discharge when documentation supports the medical necessity for the reevaluation service.

MODALITIES

Modalities chosen to treat the patient's symptoms/conditions should be selected based on the most effective and efficient means of achieving the patient's functional goals. Seldom should a patient require more than one (1) or two (2) modalities to the same body part during the therapy session. Use of more than two (2) modalities on each visit date is unusual and should be carefully justified in the documentation.

The use of modalities as stand-alone treatments is rarely therapeutic, and usually not required or indicated as the sole treatment approach to a patient's condition. The use of exercise and activities has proven to be an essential part of a therapeutic program. Therefore, a treatment plan should not consist solely of modalities, but should also include therapeutic procedures. (There are exceptions, including wound care or when patient care is focused on modalities because the acute patient is unable to endure therapeutic procedures.) Use of only passive modalities that exceeds 4 visits should be very well supported in the documentation.

Multiple heating modalities should not be used on the same day. Exceptions are rare and usually involve musculoskeletal pathology/injuries in which both superficial and deep structures are impaired. Documentation must support the use of multiple modalities as contributing to the patient's progress and restoration of function. For example, it would not be medically necessary to perform both thermal ultrasound and thermal diathermy on the

same area, in the same visit, as both are considered deep heat modalities.

When the symptoms that required the use of certain modalities begin to subside and function improves, the medical record should reflect the discontinuation of those modalities, so as to determine the patient's ability to self-manage any residual symptoms. As the patient improves, the medical record should reflect a progression of the other procedures of the treatment program (therapeutic exercise, therapeutic activities, etc.). In all cases, the patient and/or caregiver should be taught aspects of self-management of his/her condition from the start of therapy.

Hot or cold packs (to one or more areas)
Hot or cold packs (including ice massage) applied in the absence of associated procedures or modalities, or used alone to reduce discomfort are considered not to require the unique skills of a therapist.

Traction, Mechanical (to one or more areas)
Traction is generally limited to the cervical or lumbar spine with the expectation of relieving pain in or originating from those areas.

Specific indications for the use of mechanical traction include cervical and/or lumbar radiculopathy and back disorders such as disc herniation, lumbago, and sciatica.

This modality is typically used in conjunction with therapeutic procedures, not as an isolated treatment.

Equipment and tables utilizing roller systems are not considered true mechanical traction. Services using this type of equipment are non-covered.

Vasopneumatic Devices (to one or more areas)
The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema or lymphedema.

Specific indications for the use of vasopneumatic devices include reduction of edema after acute injury or lymphedema of an extremity. Education on the use of a lymphedema pump for home use is covered when medically necessary and can typically be completed in three (3) or fewer visits once the patient has demonstrated measurable benefit in the clinic environment.

Note: Further treatment of lymphedema by a vasopneumatic device rendered by a clinician after the educational visits is generally not reasonable and necessary unless the patient presents with a condition or status requiring the skills and knowledge of a physical or occupational therapist.

The use of vasopneumatic devices is generally not covered as a temporary treatment while awaiting receipt of ordered compression stockings.

Paraffin Bath (to one or more areas)
Paraffin bath treatments typically do not require the unique skills of a
therapist. However, the skills, knowledge and judgment of a therapist might be required in the provision of such treatment or baths in a complicated case. Only in cases with complicated conditions will paraffin be covered, and then coverage is generally limited to educating the patient/caregiver in home use. Paraffin is contraindicated for open wounds or areas with documented desensitization.

Whirlpool (to one or more areas)
Whirlpool bath treatments typically do not require the unique skills of a therapist. However, therapist supervision of the whirlpool modality may be medically necessary for the following indications:

- a condition complicated by a circulatory deficiency or areas of desensitization;
- an open wound which is draining, has a foul odor, or necrotic tissue;
- exfoliative skin impairments.

Dry hydrotherapy massage (also known as aquamassage, hydromassage, or water massage) is considered investigational and is non-covered.

Diathermy (i.e., microwave)
The objective of these treatments is to cause vasodilation and relieve pain from muscle spasm. Because heating is accomplished without physical contact between the modality and the skin, it can be used even if skin is abraded, as long as there is no significant edema.
Diathermy achieves a greater rise in deep tissue temperature than microwave. As diathermy is considered a deep heat treatment, careful consideration should be given to the size, location and depth of the tissue the diathermy is intended to heat. For example, it may not be appropriate to perform diathermy treatment to the wrist or hand as most intended tissues would be considered superficial and the area is relatively small.

Diathermy may be indicated when a large area of deep tissues requires heat. It would not be reasonable and necessary to perform both thermal ultrasound and diathermy to the same region of the body in the same visit as both are considered deep heat modalities.

Pulsed wave diathermy is covered for the same conditions and to the same extent as standard diathermy. (CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Section 150.5)

Diathermy is not considered reasonable and necessary for the treatment of asthma, bronchitis, or any other pulmonary condition. (CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Section 240.3) Microwave is not a covered service.

Ultraviolet (to one or more areas)
Treatment of this type is generally used for patients requiring the application of a drying heat. For example, this treatment would be considered reasonable and necessary for the treatment of severe psoriasis where there is limited range of motion.

Electrical stimulation (manual) (to one or more areas), each 15 minutes

Utilization of electrical stimulation may be necessary during the initial phase of treatment, but there must be an improvement in function. These modalities should be utilized with appropriate therapeutic procedures to effect continued improvement. Note: Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing the atrophy (e.g., post-casting or splinting of a limb, and contracture due to soft tissue scarring). Documentation must clearly support the medical necessity of electrical stimulation more than 12 visits as adjunctive therapy or for muscle retraining.

Some patients can be trained in the use of a home muscle stimulator for retraining weak muscles. Only 1-2 visits should be necessary to complete the training. Once training is completed, this procedure should not be billed as a treatment modality in the clinic.

<u>Non-covered Indications</u>

- Electrical Stimulation used in the treatment of facial nerve paralysis, commonly known as Bell’s palsy (CMS

Manual 100-03, *Medicare National Coverage Determinations (NCD) Manual*, section 160.15)
- Electrical Stimulation used to treat motor function disorders such as multiple sclerosis (CMS Manual 100-03, *Medicare National Coverage Determinations (NCD) Manual*, section 160.2)
- Electrical Stimulation for the treatment of strokes when it is determined there is no potential for restoration of function
- Electrical Stimulation when it is the only intervention utilized purely for strengthening of a muscle with at least Fair graded strength. Most muscle strengthening is more efficiently accomplished through a treatment program that includes active procedures such as therapeutic exercises and therapeutic activities.

Iontophoresis (to one or more areas)
Iontophoresis is the introduction into the tissues, by means of an electric current, of the ions of a chosen medication. This modality is used to reduce pain and edema caused by a local inflammatory process in soft tissue, e.g., tendonitis, bursitis.

The evidence from published, peer-reviewed literature is insufficient to conclude that the iontophoretic delivery of non-steroidal anti-inflammatory drugs (NSAIDs) or corticosteroids is superior to placebo when used for the treatment of musculoskeletal disorders. Therefore, iontophoresis will not be covered for these indications.

Iontophoresis will be allowed for treatment of intractable, disabling primary focal hyperhidrosis that has not been responsive to recognized standard therapy. Good hygiene measures, extra-strength antiperspirants (for axillary hyperhidrosis), and topical aluminum chloride should initially be tried.

Contrast Baths (to one or more areas)
Contrast baths are a form of therapeutic heat and cold applied to distal extremities in an alternating pattern. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold.

Hot and cold baths ordinarily do not require the skills of a therapist. However, the skills, knowledge and judgment of a therapist might be required in the provision of such treatments in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fracture or other complication.

No more than 2 visits will generally be covered to educate the patient and/or caregiver in home use, and to evaluate effectiveness. Documentation must support the medical necessity of continued use of this modality for greater than 2 visits.

Ultrasound (to one or more areas)

Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 MHz. In the human body ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone may receive as much as 30% greater dosage of ultrasound than tissue not adjacent to bone. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where tissue may receive a more intense irradiation, ultrasound is an ideal modality for increasing mobility in those tissues.

Covered ultrasound may be pulsed or continuous width, and should be used in conjunction with therapeutic procedures, not as an isolated treatment.

Specific indications for the use of ultrasound application include but are not limited to:

- limited joint motion that requires an increase in extensibility;
- symptomatic soft tissue calcification;
- neuromas.

Ultrasound application is not considered reasonable and necessary for the treatment of:

- asthma, bronchitis, or any other pulmonary condition;
- conditions for which the ultrasound can be applied by the patient without the need for a therapist or other professional to administer, and/or for extended period of time (e.g., devices such as PainShield MD);
- wounds. (see list **"ICD-10 Codes that DO NOT Support Medical Necessity"** in the related Billing and Coding Article.

Hubbard Tank (to one or more areas)

This modality involves the patient's immersion in a tank of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds, ulcers, or exfoliative skin conditions.

Qualified professional/auxiliary personnel one-on-one supervision of the patient is required. If the level of care does not require the skills of a therapist, then the service is not covered.

It is not medically necessary to have more than one form of hydrotherapy during a visit.

Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

These modalities should be utilized with appropriate therapeutic procedures to effect continued improvement. Note: Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing the atrophy (e.g., post-casting or splinting of a limb, and contracture due to soft tissue scarring).

Non-Implantable Pelvic Floor Electrical Stimulation
(CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, section 230.8.)

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

THERAPEUTIC PROCEDURES

General Guidelines for Therapeutic Procedures

Therapeutic procedures attempt to reduce impairments and restore function through the application of clinical skills and/or services. Use of these procedures is expected to result in improvement of the limitations/deficits in a

reasonable and generally predictable period of time.

Use of these procedures requires the qualified professional/auxiliary personnel to have direct (one-on-one) patient contact. Only the actual time of direct contact with the patient providing a service which requires the skills of a therapist is considered for coverage. Supervision of a previously taught exercise or exercise program, patients performing an exercise independently without direct contact by the qualified professional/auxiliary personnel, or use of different exercise equipment without requiring the intervention/skills of the qualified professional/ auxiliary personnel are not covered. The patient may be in the facility for a longer period of time, but only the time the qualified professional/auxiliary personnel is actually providing direct, one-on-one, patient contact which requires the skills of a therapist is considered covered time for these procedures, and only those minutes of treatment should be recorded.

Therapeutic Exercises to develop strength and endurance, range of motion and flexibility (one or more areas, each 15 minutes)
Therapeutic exercises are used for the purpose of restoring strength, endurance, range of motion and flexibility where loss or restriction is a result of a specific disease or injury and has resulted in a functional limitation. Therapeutic exercises may require active, active-assisted, or passive participation by the patient (e.g., isokinetic exercise, lumbar stabilization, stretching and strengthening).

Many therapeutic exercises may require the unique skills of a therapist to evaluate the patient's abilities, design the program, and instruct the patient or caregiver in safe completion of the special technique. However, after the teaching has been successfully completed, repetition of the exercise, and monitoring for the completion of the task, in the absence of additional skilled care, is non-covered.

For example, as part of the initial therapy program following total knee arthroplasty (TKA), a patient may start a session on the exercise bike to begin gentle range of motion activity. Initially the patient requires skilled progression in the program from pedal-rocks, building to full revolutions, perhaps assessing and varying the seat height and resistance along the way. Once the patient is able to safely exercise on the bike, no longer requiring frequent assessment and progression, even if set up is required, the bike now becomes an "independent" program and is no longer covered by Medicare. While the qualified professional/auxiliary personnel may still require the patient to "warm up" on the bike prior to other therapeutic interventions, it is considered a non-skilled, unbillable service and should not be included in the total timed code treatment minutes. *Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable*. However, notation of non-skilled exercises may be reported if the documentation indicates that the service was not billed (e.g., not included in the treatment minutes documented).

Exercises to promote overall fitness, flexibility, endurance (in absence of a complicated patient condition), aerobic conditioning, or weight reduction, are not covered.

Maintenance exercises to maintain range of motion and/or strength may only be covered when all criteria above for skilled maintenance therapy are met. In addition, exercises that do not require, or no longer require, the skilled assessment and intervention of a qualified professional/auxiliary personnel are non-covered. Repetitive type exercises often can be taught to the patient or a caregiver as part of a self-management, caregiver or nursing program.

Lack of exercise equipment at home does not make continued treatment in the clinic skilled or reasonable and necessary. The home program may need to be carried out through community resources.

Neuromuscular Re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (one or more areas, each 15 minutes)
This therapeutic procedure is provided for the purpose of restoring balance, coordination, kinesthetic sense, posture,

and proprioception (e.g., proprioceptive neuromuscular facilitation (PNF), BAP's boards, vestibular rehabilitation, desensitization techniques, balance and posture training).

This procedure may be reasonable and necessary for restoring prior function which has been affected by:

- loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
- nerve palsy, such as peroneal nerve injury causing foot drop;
- muscular weakness or flaccidity as result of a cerebral dysfunction, a nerve injury or disease or having had a spinal cord disease or trauma;
- poor static or dynamic sitting/standing balance;
- postural abnormalities;
- loss of gross and fine motor coordination;
- hypo/hypertonicity.

Vestibular ocular reflex training is another example where the service is mainly a patient self-directed therapy exercise following initial education. There is moderate evidence that correctly educated patients benefit from performing these exercises regularly in their home. This training can be an integral component, but not a separately payable service, of appropriate balance and gait re-training, where clinically indicated.

It may not be reasonable and necessary to extend visits for a patient with falls, or any patient receiving therapy services, if the purpose of the extended visits is to:

- remind the patient to ask for assistance;
- offer close supervision of activities due to poor safety awareness;
- remind a patient to slow down;
- offer routine verbal cues for compensatory or adaptive techniques already taught;
- remind a patient to use an assistive device; or
- train multiple caregivers

In these instances, once the appropriate cues have been determined by the qualified professional/auxiliary personnel, training of caregivers can be provided and the care should be turned over to supportive personnel or caregivers since repetitive cues and reminders do not require the skills of a therapist.

Aquatic Therapy with Therapeutic Exercises (one or more areas, each 15 minutes)
Aquatic therapy refers to any therapeutic exercise, therapeutic activity, neuromuscular re-education, or gait activity that is performed in a water environment including whirlpools, hubbard tanks, underwater treadmills and pools.

This procedure may be reasonable and necessary for the loss or restriction of joint motion, strength, mobility, balance or function due to pain, injury, or illness by using the buoyancy and resistance properties of water.

Aquatic therapy may be considered reasonable and necessary for a patient without the ability to tolerate land-based exercises for rehabilitation. Aquatic therapy exercises should be used to facilitate progression to land based therapy and to increased function. The qualified professional/auxiliary personnel does not need to be in the water with the patient unless there is an identified safety issue.

Exercises in the water environment to promote overall fitness, flexibility, improved endurance, aerobic conditioning, or weight reduction, are not covered. Exercises in the water environment for maintenance purposes may only be covered when all criteria above for skilled maintenance therapy are met.

If continued aquatic exercise is needed, the patient should be instructed in a home program during these visits. Lack of pool facilities at home does not make continued treatment skilled or reasonable and necessary. The home program may need to be carried out through community resources.

Consider the following points when providing aquatic therapy services.

- Does your patient require the skills as a therapist, or could the patient achieve functional improvement through a community-based aquatic exercise program?
- There are a limited number of therapeutic exercises generally performed in the water. These exercises become repetitive quickly. Once a patient can demonstrate an exercise safely, you may no longer bill Medicare for the time it takes the patient to perform this now independent exercise. If the same exercise is performed over a number of sessions, the documentation must describe the skilled nature of the qualified professional's/auxiliary personnel's intervention during the therapeutic exercise to support the ongoing medical necessity.
- Patients who will not be continuing their water-based program as a maintenance program should be transitioned to land-based exercises as soon as reasonably possible for the patient's condition.

Gait Training (includes stair climbing) (one or more areas, each 15 minutes)

This procedure may be reasonable and necessary for training patients and instructing caregivers in ambulating patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

Indications for gait training include, but are not limited to:

- a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation;
- musculoskeletal trauma, requiring ambulation reeducation;
- a chronic, progressively debilitating condition for which safe ambulation has recently become a concern;
- an injury or condition that requires instruction in the use of a walker, crutches, or cane;
- a patient fitted with a brace or lower limb orthosis or prosthesis and requires instruction in ambulation;
- a condition that requires retraining in stairs/steps or other uneven surfaces appropriate to home and community function (ramps, inclines, curbs, grass, etc.);
- instructing a caregiver in appropriate guarding and assistive techniques.

Gait training is not considered reasonable and necessary when the patient's walking ability is not expected to improve.

Repetitive walk-strengthening exercise (such as for feeble patients or to increase endurance or gait distance) does not require the skills of the therapist and is considered not reasonable and necessary and is non-covered.

Antalgic gait alone does not support the need for ongoing skilled gait training. Antalgic gait refers to a gait pattern assumed in order to avoid or lessen pain. Limited gait training may be appropriate, when supported as medically necessary in the documentation, to teach the patient improved gait patterns to reduce the stress on the painful area. In most circumstances, as the pain decreases (with or without skilled therapy intervention) the gait will improve spontaneously without the need for skilled gait training intervention.

Coverage for NMES/FES for walking will be covered in SCI patients with all of the following characteristics:

- Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);
- Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate

balance and control to maintain an upright support posture independently;
- Persons that demonstrate brisk muscle contraction to NMES and have sensory perception [of] electrical stimulation sufficient for muscle contraction;
- Persons that possess high motivation, commitment and cognitive ability to use such devices for walking;
- Persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;
- Persons that can demonstrate hand and finger function to manipulate controls;
- Persons with at least 6-month post recovery spinal cord injury and restorative surgery;
- Persons with[out] hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
- Persons who have demonstrated a willingness to use the device long-term.

(Italicized information about NMES for walking in SCI patients is from CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, section 160.12)

Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) (one or more areas, each 15 minutes) Massage may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to reduce edema, improve joint motion, or relieve muscle spasm.

Massage chairs, aquamassage tables and roller beds are not considered massage. These services are non-covered.

Massage is not covered as an isolated treatment.

Manual Therapy Techniques (e.g.,mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

- Manual traction may be considered reasonable and necessary for cervical dysfunctions such as cervical pain and cervical radiculopathy.
- Joint Mobilization (peripheral and/or spinal) may be considered reasonable and necessary if restricted or painful joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.
- Myofascial release/soft tissue mobilization, one or more regions, may be reasonable and necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems.
- Manipulation, which is a high-velocity, low-amplitude thrust technique or Grade V thrust technique, may be reasonable and necessary for treatment of painful spasm or restricted motion in the periphery, extremities or spinal regions.
- Manual lymphatic drainage/complex decongestive therapy (MLD/CDT)
  MLD / CDT is indicated for both primary and secondary lymphedema. Lymphedema in the Medicare population is usually secondary lymphedema, caused by known precipitating factors. Common causes include surgical removal of lymph nodes, fibrosis secondary to radiation, and traumatic injury to the lymphatic system.
  Both primary and secondary lymphedemas are chronic and progressive conditions which can be brought under long-term control with effective management. By maintaining control of the lymphedema, patients can:
    - restore a normal, or near-normal, shape;
    - reduce the potential for complications (e.g., cellulitis, lymphangitis, deformity, injury, fibrosis, lymphangiosarcoma (rare), etc.);
    - reduce functional deficits to resume activities of daily living.

- MLD/CDT consists of skin care, manual lymph drainage, compression wrapping, and therapeutic exercises. Coverage of MLD / CDT would only be allowed if all of the following conditions have been met:
    - there is a physician-documented diagnosis of lymphedema (primary or secondary);
    - the patient has documented signs or symptoms of lymphedema;
    - the patient or patient caregiver has the ability to understand and comply with the continuation of the treatment regimen at home.
- The goal of treatment is to reduce lymphedema of an extremity by routing the fluid to functional pathways, preventing backflow as the new routes become established, and to use the most appropriate methods to maintain such reduction of the extremity after therapy is complete. This therapy involves intensive treatment to reduce the volume by a combination of manual decongestive therapy and serial compression bandaging, followed by an exercise program. Ultimately the plan must be to transfer the responsibility of care from the therapist to management by the patient, patient's family, or patient's caregiver.
    - In moderate-severe lymphedema, daily visits may be required for the first week.
    - Education should be provided to the patient and/or caregiver on the correct application of the compression bandage.
- MLD/CDT is not covered for:
    - conditions reversible by exercise or elevation of the affected area;
    - dependent edema related to congestive heart failure or other cardiomyopathies;
    - patients who do not have the physical and cognitive abilities, or support systems, to accomplish self-management in a reasonable time;
    - continuing treatment for a patient non-compliant with a program for self-management.

Therapeutic Procedure(s), Group (2 or more individuals)

Group therapy procedures involve constant attendance of the physician, NPP, therapist, or assistant, but by definition do not require one-on-one patient contact.

Supervision of a previously taught exercise program or supervising patients who are exercising independently is not a skilled service and is not covered as group therapy or as any other therapeutic procedure. Supervision of patients exercising on machines or exercise equipment, in the absence of the delivery of skilled care, is not a skilled service and is not covered as group therapy or as any other therapeutic procedure.

Non-covered as group therapy

- Groups directed by a student, therapy aide, rehabilitation technician, nursing aide, recreational therapist, exercise physiologist, or athletic trainer
- Routine (i.e., supportive) groups that are part of a maintenance program, nursing rehabilitation program, or recreational therapy program
- Groups using biofeedback for relaxation
- Viewing videotapes; listening to audiotapes
- Group treatment that does not require the unique skills of a therapist

Therapeutic Activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

Therapeutic activities are considered reasonable and necessary for patients needing a broad range of rehabilitative techniques that involve movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, pushing, pinching, grasping, transfers, bed mobility and overhead activities) to restore 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 skills of the therapist to design the activities to address a specific functional need of the patient and to instruct the patient in their performance. These dynamic activities must be part of an active treatment plan and must be directed at a specific outcome.

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

- the patient has a documented condition for which therapeutic activities can reasonably be expected to restore or improve functioning;
- there is a clear correlation between the type of therapeutic activity performed and the patient's underlying medical condition;
- the patient's condition is such that he/she is unable to perform the therapeutic activities without the skilled intervention of the qualified professional/auxiliary personnel.

Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training) direct (one-on-one) patient contact, each 15 minutes

This activity is designed to improve attention, memory, and problem-solving, including the use of compensatory techniques. Cognitive skill training may be medically necessary for patients with acquired cognitive deficits resulting from head trauma, or acute neurologic events including cerebrovascular accidents. Impaired functions may include but are not limited to ability to follow simple commands, attention to tasks, problem solving skills, memory, ability to follow numerous steps in a process, perform in a logical sequence and ability to compute. Conditions without potential for improvement or restoration, such as chronic progressive brain conditions, would not be appropriate. Evidence-based reviews indicate that cognitive rehabilitation (and specifically memory rehabilitation) is not recommended for patients with severe cognitive dysfunction. Cognitive skill training should be aimed towards improving or restoring specific functions which were impaired by an identified illness or injury, and expected outcomes should be reasonably attainable by the patient as specified by the plan of care.

Those services that a patient may engage in without a skilled therapist qualified professional/auxiliary personnel are not covered under the Medicare benefit.

Sensory integration

Sensory integrative techniques are performed to enhance sensory processing and promote adaptive responses to environmental demands. These treatments are performed when a deficit in processing input from one of the sensory systems (e.g., vestibular, proprioceptive, tactile, visual or auditory) decreases an individual's ability to make adaptive sensory, motor and behavioral responses to environmental demands. Individuals in need of sensory integrative treatments demonstrate a variety of problems, including sensory defensiveness, over-reactivity to environmental stimuli, attention difficulties, and behavioral problems.

Sensory integration treatments are often associated with pediatric populations. For non-pediatric patients, these services may be medically necessary for acquired sensory problems resulting from head trauma, illness, or acute neurologic events including cerebrovascular accidents. They are not appropriate for patients with progressive neurological conditions without potential for functional adaptation. Therapy is not considered a cure for sensory integrative impairments, but is used to facilitate the development of the nervous system's ability to process sensory input differently.

Self–care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes

This procedure is reasonable and necessary only when it requires the skills of a therapist, is designed to address

specific needs of the patient, and is part of an active treatment plan directed at a specific outcome.

The patient must have a condition for which self-care/home management training is reasonable and necessary. The training should be focused on a functional limitation(s) in which there is potential for improvement in a functional task that will be meaningful to the patient and the caregiver. The patient and/or caregiver must have the capacity and willingness to learn from instructions. Documentation must relate the training to expected functional goals that are attainable by the patient.

Services provided to the same patient by physical therapy and occupational therapy may be covered if separate and distinct goals are documented in the treatment plans and there is no duplication of services.

Many ADL/IADL (instrumental activities of daily living) impairments may require the unique skills of a therapist to evaluate the patient's abilities, design the program and instruct the patient or caregiver in safe completion of the special technique. However, repetitious completion of the activity, once taught and monitored, is non-covered care.

Community/Work Reintegration Training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis) direct one-on-one contact, each 15 minutes

This training may be medically necessary when performed in conjunction with a patient's individual treatment plan aimed at improving or restoring specific community functions which were impaired by an identified illness or injury and when realistically expected outcomes are specified in the plan.

General activity programs, and all activities which are primarily social or diversional in nature, will be denied because the professional skills of a therapist are not required. Services must be necessary for medical treatment of an illness or injury rather than related solely to specific leisure or employment opportunities, work skills or work settings.

Under the Occupational Therapy benefit, this service may be covered for the provision of compensatory training of patients in driving techniques. The patients must be identified as meeting Medicare criteria for coverage:

- the need for therapy is a result of an identified injury or illness, NOT simply generalized aging, weakness or debility;
- the need for therapy must be demonstrated by an assessment which shows the patient has a reasonable expectation of being able to drive a vehicle after being treated under an occupational therapy plan of care;
- assessments performed only for the purpose of disqualifying the patient from driving are not a covered benefit.

Wheelchair Management (e.g., assessment, fitting, training), each 15 minutes
This service is used to reflect the skilled wheelchair management intervention clinicians provide related to the assessment, fitting and/or training for patients who must utilize a wheelchair for mobility. This service trains the patient, family and/or caregiver in functional activities that promote safe wheelchair mobility and transfers. Patients who are wheelchair bound may occasionally need skilled input on positioning to avoid pressure points, contractures, and other medical complications.

Consider the following points when providing wheelchair management services.

- Assessment for non-specialized wheelchairs, cushions, lapboards, wheelchair trays, or lap buddies for a patient without a complicating condition typically does not require the unique skills of a therapist.
- A seating assessment is not medically necessary for every patient.
- Skilled intervention would not be necessary for wheelchair issues that the patient can self-correct.
- The patient/caregiver must have the capacity and willingness to learn from instructions.

- When wheelchair and seating assessments are reasonable, care should be turned over to supportive personnel or a caregiver once the necessary modifications are completed.
- Ongoing visits for increasing sitting times are generally not reasonable and necessary when no patient problems are documented.
- Visits made for restraint reduction are generally non-covered.
- It is expected that multiple wheelchair and seating deficits discovered during the initial evaluation would be treated concurrently. If not, documentation must indicate that a new problem/deficit occurred, or include rationale why a problem being treated in the later stages of therapy was not addressed previously.

Work hardening/conditioning
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.

Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Active wound care procedures are performed to remove devitalized tissue and promote healing, and involve selective and non-selective debridement techniques. Debridement is indicated whenever necrotic tissue is present in an open wound. Debridement may also be indicated in cases of abnormal wound healing or repair. Debridement will not be considered a reasonable and necessary procedure for a wound that is clean and free of necrotic tissue.

Note: While debridement is considered a covered service for appropriately selected wounds, the following services are considered non-covered for the treatment of wounds.

- Topical application of oxygen (CMS Publication 11-03, *Medicare National Coverage Determinations (NCD) Manual*, section 270.4.)
- Ultrasound
- Infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE) (CMS Publication 11-03, *Medicare National Coverage Determinations (NCD) Manual*, section 270.6.)
- Low Level Laser Treatment (LLLT) (refer to CPT code 0552T)
- Magnet therapy
- Autologous blood-derived products for chronic, non-healing wounds (CMS Publication 11-03, *Medicare National Coverage Determinations (NCD) Manual*, section 270.3.)
- Routine dressing changes
- Non-Contact Normothermic Wound Therapy (NNWT) (CMS Publication 11-03, *Medicare National Coverage Determinations (NCD) Manual*, section 270.2.)

Negative pressure wound therapy (eg,vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session;

Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session;

Negative pressure wound therapy (NPWT) involves negative pressure to the wound bed to manage wound exudates and promote wound healing. NPWT consists of a sterile sponge held in place with transparent film, a drainage tube inserted into the sponge, and a connection to a vacuum source.

NPWT is indicated for use as an adjunct to standard treatment in carefully selected patients who have failed all other forms of treatment. NPWT may be indicated for wounds such as:

- Stage III or IV pressure ulcers;
- Neuropathic (for example, diabetic) ulcers;
- Chronic arterial or venous insufficiency ulcers;
- Complications of surgically created or traumatic wounds.

NPWT is not covered for:

- Stage I or II pressure ulcers;
- Wounds with eschar if debridement is not attempted;
- Untreated osteomyelitis within the vicinity of the wound;
- Cancer present in the wound;
- Active bleeding;
- The presence of a fistula to an organ or body cavity within the vicinity of the wound.

Physical Performance Test or Measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes
Physical performance testing may be reasonable and necessary for patients with neurological, musculoskeletal, or pulmonary conditions.

It is not reasonable and necessary for the test to be performed and billed on a routine basis (i.e., monthly or instead of billing a reevaluation) or to be routinely performed on all patients treated.

Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
The provider performs an assessment of the suitability and benefits of acquiring any assistive technology device or equipment that will help restore, augment, or compensate for existing functional ability in the patient (e.g., provision of large amounts of rehabilitative engineering).

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

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

An orthotic is a brace that includes rigid and semi-rigid components that are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. (Elastic stockings, garter belts, neoprene braces and similar devices do not come within the scope of the definition of a brace.) HCFA Ruling 96-1 clarifies that the "orthotics" benefit is limited to leg, arm, back, and neck braces that are used independently rather than in conjunction with, or as components of, other medical or non-medical equipment.

When consideration is made for a patient to require an orthotic, the therapist targets the problems in performance of movements or tasks, or identifies a part that requires immobilization, and selects the most appropriate orthotic device, then fits the device, and trains the patient and/or caregivers in its use and application. The goal is either to promote indicated immobilization or to assist the patient to function at a higher level by decreasing functional

limitations or the risk of further functional limitations.

The complexity of the patient's condition is to be documented to show the medical necessity of skilled therapy to assess, fit, and instruct in the use of the orthotic.

An orthotic may be prefabricated or custom-fabricated.

A prefabricated orthotic is one that is manufactured in quantity and then modified with a specific patient in mind. A prefabricated orthotic may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). An orthotic that is assembled from prefabricated components is considered prefabricated.

A custom fabricated orthotic is one that is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth, from the patient's individualized measurements.

A molded-to-patient model orthotic is a particular type of custom fabricated orthotic in which an impression of the specific body part is made and the impression is then used to make a positive model. The orthotic is molded from the patient-specific model.

For **uncomplicated** conditions, the following services would not be considered reasonable and necessary as they would not require the unique skills of a therapist.

- Issuing off-the-shelf splints for foot drop or wrist drop
- Issuing off-the-shelf foot or elbow cradles for routine pressure relief (these are not considered orthotics)
- Issuing "carrots" (i.e., cylindrical, cone-shaped forms) or towel rolls for hand contractures for hygiene purposes
- Bed positioning (e.g., pillows, wedges, rolls, foot cradles to relieve potential pressure areas)

Repetitive range of motion prior to placing an orthotic/positioner to maintain the range of motion is not reasonable and necessary when the therapeutic intent is primarily to maintain range of motion within a chronic condition, except when all criteria above for maintenance programs are met.

Ongoing therapy visits for increasing wearing time are generally not reasonable and necessary when patient problems related to the orthotic have not been observed.

Prosthetic training, upper and/or lower extremity(s), initial prosthetic(s) encounter, each 15 minutes
Prosthetic training is the professional instruction necessary for a patient to properly use an artificial device that has been developed to replace a missing body part.

Prosthetic training includes preparation of the stump, skin care, modification of prosthetic fit (revisions to socket liner or stump socks), and initial mobility and functional activity training.

These assessments may not be considered reasonable and necessary when a device is newly issued or when a device is reissued or replaced after normal wear and no modifications are needed.

Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30

days of conventional care as part of a therapy plan of care

ES and electromagnetic therapy services can only be covered when performed by a therapist, a physician or incident to a physician's service.

Evaluation of the wound is an integral part of wound therapy. When providing ES or electromagnetic therapy, the therapist must evaluate and frequently reassess the wound, contacting the treating physician if the wound worsens

Other Available Therapy Services

Muscle and Range of Motion Testing

Assessments must be provided by therapists or physician/NPP (not therapy assistants) and include objective testing and measurement (such as ROM and manual muscle testing) to make clinical judgments regarding the patient's condition to determine the next step in the treatment plan.

On rare occasions, it may be appropriate to perform a thorough range of motion or manual muscle test during the course of treatment that is separate from the evaluation/reevaluation. Patients with complicated conditions may warrant specialized tests and measures with standardized reports. For example, a patient with an incomplete C5 quadriplegia at six months post-injury may need specialized testing for ROM or strength measurements to address specific deficits and goals.

Testing must be pertinent to the plan of care and the diagnosis.

It is not reasonable or necessary for these codes to be performed on a routine basis or to be routinely used for all patients (e.g., monthly or in the place of billing for a reevaluation).

Application of Casts, Strapping and Splinting Codes
The casting and strapping procedures apply when the cast application or strapping is a replacement procedure used during or after the period of follow-up care, or when the cast application or strapping is an initial service performed without a restorative treatment or procedure(s) to stabilize or protect a fracture, injury, or dislocation and/or to afford comfort to a patient.

General Guidelines for Casting
Therapists typically do not utilize casting interventions for the treatment of fractures. However, casting techniques used by therapists for positioning and stretching are a covered service when an improvement can be noted in an individual's movement patterns and skills. For example, a spastic hand can be casted to facilitate relaxation of the fingers. Serial casting can be essential for individuals with traumatic brain injury-induced spasticity, CVA, and other conditions. Casting should not be utilized for basic contracture management issues. Casting goals should objectively indicate expectation of progress, whereas, the main function of contracture management is to decrease the risk of further contracture.

General Guidelines for Strapping

Strapping refers to the application of overlapping strips of adhesive plaster or tape to a body part to exert pressure and hold a structure in place. Strapping may be used to treat strains, sprains, dislocations, and some fractures. The strapping codes are intended to be used when the desired effect is to provide total immobilization or restriction of movement. These services are typically performed outside a therapy plan of care.

Special instructions for Strapping; Unna boot
The application of Unna boot paste (zinc, gelatin, or other product) as a bandage or "colloid" dressing, is applied to

an extremity for the treatment of dermatological, vascular, and on occasion, other conditions. These dressings are often covered by an elastic bandage to give added support, hold the dressing in place and provide a protective cover. Unna boot application is appropriate in the treatment of ulcerations with and without inflammation due to stasis dermatitis produced by vascular insufficiency. The Unna boot is also appropriate for treating ligamentous injuries (sprains and strains) of the ankle. Unna boots need to be changed on a regular basis, depending on the exact type used and the indication.

General Guidelines for Splinting

Splinting codes, though rarely used by therapists, may be appropriate for clinical situations (e.g., fracture, sprain, dislocation) where temporary immobilization/fixation is required until there is further treatment disposition.

Biofeedback training by any modality

Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry
Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Medicare will allow biofeedback as an initial incontinence treatment modality only when, in the opinion of the physician, that approach is most appropriate and there is documentation of medical justification and rationale for why a PME trial was not attempted first.

Patient selection is a major part of the process and the patient should be motivated, cognitively intact, and compliant. In addition, there must be assurance that the pelvic floor musculature is intact. Biofeedback therapy has proven successful for urinary incontinence when all three of the following conditions exist:

- the patient is capable of participation in the plan of care;
- the patient is motivated to actively participate in the plan of care, including being responsive to the care requirements (e.g., practice and follow-through by self or caregiver); and
- the patient's condition is appropriately treated with biofeedback (e.g., pathology does not exist preventing success of treatment).

Biofeedback is non-covered for:

- home use of biofeedback therapy;
- pelvic floor electrical stimulation lacking documentation of the failure of a trial of pelvic muscle exercise (PME) training, unless there is physician documentation justifying the need to initiate treatment with biofeedback before PME is attempted;
- patients who do not have sufficient cognitive ability to adhere to and follow the PME protocol and/or cooperate in keeping a personal voiding diary.

Patients not showing improvement after 5-6 visits of retraining with biofeedback are not likely to improve with additional sessions.

Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day
Canalith repositioning is used for the treatment of benign paroxysmal positional vertigo (BPPV). It is covered when performed by physicians, qualified non-physician providers and therapists. The procedure is covered as a single service per day, regardless of the duration required to provide the service or the number of repeat services. It is anticipated that the frequency and the total number of this service provided would be limited to five or fewer encounters, as the patient may be able to be trained to perform these maneuvers on his/her own without the assistance/supervision of a trained professional. The medical record should include documentation of the plan of care, the patient's progress, and conditions requiring continued supervision by a trained professional. When provided during the same encounter as an E&M service, subsequent to the diagnosis of and first encounter for the BPPV, a significant and separately identifiable reason supporting the E&M service should be present.

Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

According to CPT 2008 Changes, An Insider's View, patients who have compromised functioning abilities due to acute neurological events such as TBI or CVA must undergo assessment to determine if abilities such as orientation, memory and high-level language function have been comprised and to what extent. Health care professionals such as speech-language pathologists (SLPs) and OTs perform a battery of test procedures called standardized cognitive performance testing in order to make these important determinations. These tests evaluate different aspects of neurocognitive function including memory (short-term, long-term, and organizational), reasoning, sensory processing, visual perceptual status, orientation, right hemisphere processing for temporal and spatial organization, social pragmatics, and elements of decision-making and executive function.

Miscellaneous Services (Non-covered)
The following are non-covered as skilled therapy services. This is not an all inclusive list.

- Iontophoresis, except as indicated for primary focal hyperhidrosis
- Anodyne
- Low level laser treatment (LLLT)/cold laser therapy
- Dry hydrotherapy massage (e.g., aquamassage, hydromassage, or water massage)
- Massage chairs or roller beds
- Interactive metronome therapy
- Loop reflex training
- Vestibular ocular reflex training
- Continuous passive motion (CPM) device setup and adjustments
- Craniosacral therapy
- Electro-magnetic therapy, except as indicated for chronic wounds
- Constraint Induced Movement Therapy (CIMT)
- Work-hardening programs
- Pelvic Floor Dysfunction (not including incontinence)
    - Due to the lack of peer reviewed evidence concerning the effect on patient health outcomes, skilled therapy interventions (e.g., ultrasound, electrical stimulation, soft tissue mobilization, and therapeutic exercise) for the treatment of the following conditions is considered investigational and thus non-covered.
        - pelvic floor congestion
        - pelvic floor pain not of spinal origin
        - hypersensitive clitoris
        - prostatitis

    - cystourethrocele
    - enterocele
    - rectocele
    - vulvodynia
    - vulvar vestibulitis syndrome (VVS)
- Frequency Specific Microcurrent: non-covered due to lack of medical literature supporting the effectiveness of this therapy
- Whole body periodic acceleration: does not meet the benefit requirement that it requires the services of a skilled professional
- Light beam Generator therapy: non-covered due to lack of medical literature supporting the effectiveness of this therapy
- Functional Electrical Stimulating (FES) devices other than those
  that assist in walking are not covered under Medicare [NCD 160.12]. Consequently, any services related to the evaluation for or training of patients to use such a device is not covered. Such devices may include, but are not limited, to the Ergys® system.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

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N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
01/01/2020	R15	This LCD was converted to the "No-codes" format. There has been no change in coverage with this LCD revision.	• Revisions Due To Code Removal
12/19/2019	R14	Coding guidelines, all Code sections, Documentation Requirements and Utilization Guidelines have been moved to Billing and Coding Article, A56566, linked to this LCD.	• Revisions Due To Code Removal
10/01/2019	R13	LCD revised for annual ICD-10 update for 2020. ICD-10	• Revisions Due To ICD-10-CM Code

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		codes L89.006, L89.016, L89.026, L89.106, L89.116, L89.126, L89.136, L89.146, L89.156, L89.206, L89.216, L89.226, L89.306, L89.316, L89.326, L89.46, L89.506, L89.516, L89.526, L89.606, L89.616, L89.626, L89.816, L89.896 and L89.96 were added to the list of non-covered diagnoses for CPT 97035.	Changes
07/01/2019	R12	LCD revised effective July 1, 2019 to add CPT code 0552T (Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional) as non-covered, to the CPT/HCPCS section, and elsewhere where the service is listed in the LCD.	• Revisions Due To CPT/HCPCS Code Changes
01/01/2019	R11	CMS Transmittal No. 4149, dated October 23, 2018, removed Functional Reporting requirements and edits for outpatient therapy services, effective January 1, 2019. Documentation Requirements and CMS National Coverage sections have been updated accordingly. *DATE 01/01/2019: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not all the fields included are applicable as noted in this policy.*	• Provider Education/Guidance
01/01/2019	R10	LCD revised to remove diagnosis codes listed for HCPCS code G0515 (Cognitive skills development) and restate diagnosis requirements for this service. *DATE 01/01/2019: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not all the fields included are applicable as noted in this policy.*	• Provider Education/Guidance
10/01/2018	R9	LCD updated for annual ICD-10 updates to revise descriptors for ICD-10 codes L98.495, L98.496, L98.498. *DATE 10/01/2018: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not*	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		all the fields included are applicable as noted in this policy.	
01/01/2018	R8	LCD revised for annual HCPCS update. CPT code 97532 has been deleted and replaced by HCPCS code G0515. CPT codes 97760 and 97761 have been revised, and CPT code 97762 has been deleted and replaced by code 97763. Indications and guidelines for these services have been updated to accommodate the new and revised code descriptions. *DATE 01/01/2018: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not all the fields included are applicable as noted in this policy.*	• Revisions Due To CPT/HCPCS Code Changes
10/01/2017	R7	LCD revised for annual ICD-10 updates for 2018. ICD-10 codes L97.105, L97.106, L97.108, L97.115, L97.116, L97.118, L97.125, L97.126, L97.128, L97.205, L97.206, L97.208, L97.215, L97.216, L97.218, L97.225, L97.226, L97.228, L97.305, L97.306, L97.308, L97.315, L97.316, L97.318, L97.325, L97.326, L97.328, L97.405, L97.406, L97.408, L97.415, L97.416, L97.418, L97.425, L97.426, L97.428, L97.505, L97.506, L97.508, L97.515, L97.516, L97.518, L97.525, L97.526, L97.528, L97.805, L97.806, L97.808, L97.815, L97.816, L97.818, L97.825, L97.826, L97.828, L97.905, L97.906, L97.908, L97.915, L97.916, L97.918, L97.925, L97.926, L97.928, L98.415, L98.416, L98.418, L98.425, L98.426, L98.428, L98.495, L98.496, and L98.498 were added to the list of non-covered diagnoses for CPT code 97035. *DATE (10/01/2017): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
01/01/2017	R6	LCD revised for CPT code updates effective 1/1/2017. CPT codes 97001-97004 have been replaced with CPT codes 97161-97168 in Indications and Limitations, CPT/HCPCS codes, Documentation Requirements, and Utilization Guidelines sections of the LCD. The descriptor for CPT code 97602 has been revised.	• Revisions Due To CPT/HCPCS Code Changes
08/01/2016	R5	References to Article A52862, Outpatient Physical and Occupational Therapy Services – Supplemental Instructions Article, have been deleted from Documentation sections for CPT codes 97039, 97139, 97799, and 29799. This article has been retired effective 8/1/2016.	• Other
04/01/2016	R4	Provisions and references related to CPT codes 97597 and 97598 were deleted from the LCD and have been added to LCD L33614, Debridement Services, effective 04/01/2016. Definitions of ADL (activities of daily living) and IADL (instrumental activities of daily living) were added to references in Indications.	• Provider Education/Guidance
10/01/2015	R3	ICD-10 codes were revised to add the 7th digit for D=subsequent encounter and S=sequela, where the 7th digit, A=initial encounter was already included.	• Provider Education/Guidance
10/01/2015	R2	Converted ICD-9 code 386.11 to H81.11-H81.13 for CPT code 95992.	• Other
10/01/2015	R1	LCD updated with changes made since April 2014.	• Other

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A56566 - Billing and Coding: Outpatient Physical and Occupational Therapy Services

Related National Coverage Documents

N/A

Public Versions

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