Outpatient Physical and Occupational Therapy

Guideline Number: CS164.H
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Instructions for Use

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Application

This Coverage Determination Guideline only applies to the states of Arizona, California, Hawaii, Kansas, Maryland, Michigan, New York, Ohio, Rhode Island, Virginia, Washington, and Wisconsin.

Refer to the guidelines listed below for the following states:

State	Policy/Guideline
Indiana	Outpatient Therapy Services (for Indiana Only)
Florida	Outpatient Speech, Occupational and Physical Therapy Services (for Florida Only) Outpatient Speech, Occupational and Physical Therapy – Site of Service (for Florida Only)
Kentucky	Outpatient Physical, Occupational, and Speech Therapy (for Kentucky Only)
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New Jersey	Outpatient Physical and Occupational Therapy (for New Jersey Only)
North Carolina	Outpatient Physical and Occupational Therapy (for North Carolina Only)

Coverage Rationale

Requirements for Coverage

Occupational Therapy and/or Physical Therapy evaluation and treatment services are considered Medically Necessary when a member meets all of the following criteria:

- The member exhibits signs and symptoms of a Functional or Physical Impairment as evidenced by the inability to perform basic activities of daily living (ADLs) (for example, functional mobility, feeding, dressing, bathing, or toileting) or instrumental activities of daily living (IADLs) (for example, making a bed), or usual daily activities
- The member exhibits signs and symptoms of physical deterioration or impairment in one or more of the following areas:

- Sensory and/or motor ability: Problems with sensory integration, cranial and peripheral nerve integrity, ergonomics and body mechanics, joint integrity and mobility, motor function, muscle performance, neuromotor development, posture, range of motion, sensory integrity, swallowing, or feeding
- Cognitive/psychological ability: Problems with orientation, concentration (attention loss), comprehension, organization of thought, problem-solving, or memory
- Cardiopulmonary status: Impairments in aerobic capacity, aerobic endurance, ventilation, or respiration change; and/or
- Skin and circulation: Integumentary integrity or circulation

Treatment

- Treatment must be ordered by a physician and be Medically Necessary for the member's plan of care (POC)
- Treatment requires the judgment, knowledge, and skills of a licensed/registered occupational or physical therapist and cannot be reasonably learned and implemented by non-professional or lay caregivers
- Treatment meets accepted Generally Accepted Standards of Practice, and is targeted and effective in the treatment of the member's diagnosed impairment or condition
- Treatment is expected to produce clinically significant and measurable improvement in the member's level of functioning within a reasonable and medically predictable period of time; or the treatment is part of a Medically Necessary program to prevent significant functional regression and meets one of the following criteria:
  - When a member achieves a functional plateau, the provider adjusts the plan of care (POC) accordingly and provides monthly (or as appropriate) reassessments to update and modify the home program
  - When members who have received Physical and Occupational Therapy services experience a loss or regression of present level of function it may be Medically Necessary to resume or increase frequency of therapy
- The services are not Duplicate Services of another service provided concurrently by any other type of therapy (such as speech, Physical and Occupational Therapy), and must provide different treatment goals, plans, and therapeutic modalities

Sites of Service

Sites of service for outpatient Physical and Occupational Therapy procedures must be Medically Necessary, including cost effective, as defined below.

An outpatient hospital site of care for outpatient therapy is considered Medically Necessary for an individual who meets any of the following conditions:

- Part of an annual or semi-annual Comprehensive Care Management assessment clinic visit for:
  - Paraplegia
  - Quadriplegia
  - Traumatic brain injury
- Medical complications related to the following:
  - Immediately following amputation
  - Major multiple trauma
  - Post-acute stroke
  - Severe burn injury

The following will be taken into account to determine whether the Physical and Occupational Therapy sessions can be performed in a more cost-effective setting:

- State Medicaid contract;
- Applicable federal and/or state requirements;
- Geographic availability of an in-network provider; and
- Free standing clinic/facility capability to accommodate all Medically Necessary services

For Medical Necessity Clinical Coverage Criteria

Refer to the InterQual® 2022, Mar. 2022 Release, LOC: Outpatient Rehabilitation & Chiropractic.

Click here to view the InterQual® criteria.

Early Childhood Intervention (ECI) and State/School-Based Services

Children Under Age 3

Federal Early Periodic Screening, Diagnostic, and Treatment (EPSDT) and/or disability regulations may provide certain Physical and Occupational Therapy Services to children under three years of age pursuant to the needs documented in an Individualized Family Service Plan (IFSP). States have a responsibility to implement these requirements and are given broad flexibility in how to implement them.

- An IFSP may identify certain Physical and Occupational Therapy Services as a needed by a child. For members who are eligible for an IFSP under applicable law, all of the following apply:
  - A request for Physical and Occupational Therapy Services must include: (1) a written attestation stating that the member has not been evaluated or has declined an evaluation for an IFSP; or (2) a copy of the IFSP; or (3) the requesting therapist must include a description of the goals and objectives from the therapists coordinating care if the current IFSP is not available;
  - A request for Physical and Occupational Therapy Services that circumvents or attempts to circumvent those Physical and Occupational Therapy Services identified in the IFSP and which is authorized by an applicable state entity shall not be authorized (Note: Requesters will be directed back to the applicable state entity as appropriate);
  - A request for Physical and Occupational Therapy Services may be denied if the request duplicates the goals identified in the member's IFSP and is authorized by an applicable state entity. There are some members due to the significance of their medical condition who could need services both from ECI as well as through UHC because they are not addressing duplicate goals; and
  - If appropriate, a member who does not have an IFSP in place, but whose goals and assessment appear to be such that the services would be covered under an IFSP, will be referred to the local area agency to obtain the requested services.

Children Age 3 and Up Until the Child's 21st Birthday

Federal EPSDT and/or disability regulations require the development and implementation of an Individualized Education Program (IEP) that addresses the developmental needs of each child with a disability ages 3 through 21. States have a responsibility to implement these requirements and are given broad flexibility in how to implement them.

- An IEP may identify certain Physical and Occupational Therapy Services as a needed by a child. For members who are eligible for an IEP under applicable law, all of the following apply:
  - A request for Physical and Occupational Therapy Services must include: (1) a written attestation stating that the member has not been evaluated or has declined an evaluation for an IEP; or (2) a copy of the member's IEP; or (3) the requesting therapist must include a description of the goals and objectives from the therapists coordinating care if the current IFSP is not available;
  - A request for Physical and Occupational Therapy Services that circumvents or attempts to circumvent those Physical and Occupational Therapy Services identified in the member's IEP and which is authorized by an applicable school/state entity shall not be authorized (Note: Requesters will be directed back to the applicable school/state entity as appropriate);
  - If there is no relationship between the child and an applicable school/state entity, reasonable support may be provided to the requester to coordinate services;
  - A request for Physical and Occupational Therapy Services may be denied if the request duplicates services identified in the member's IEP and is authorized by an applicable state/school entity; and
  - If appropriate, a member who has not been evaluated for an IEP, but whose goals are related to skills that are routinely taught as part of a school curriculum will be deemed educational in nature, rather than Medically Necessary, and the member will be referred to the applicable school/state entity to obtain the requested services.

Required Documentation

Initial Therapy Evaluation/Initial Therapy Visit Requests

A physician referral and a copy of the well child check or intermediary physician visit documenting the need for the Physical and Occupational Therapy evaluation must be on file prior to the completion of the evaluation. In states where evaluation and treatment are allowed on the same day of service, the referring physician may request an initial evaluation and up to four treatment visits. If continued care is needed after the fourth treatment visit, the therapy provider practicing in a state that participates in the prior authorization program must submit a prior authorization request for more visits. A therapy provider practicing in a state that does not participate in the prior authorization program is not required to submit a prior authorization request for more visits. The therapy evaluation report must include all of the following:

- A statement of the member's medical history (to include relevant review of systems, onset date of the illness, injury, or exacerbation and any prior therapy treatment); and
- Identification of durable medical equipment needed for this condition (if applicable); and
- Identification of the number of medications the member is taking and type (if known); and
- A description of the member's Functional Impairment including its impact on their health, safety, and/or independence; and
- A comparison prior level of function to current level of function, as applicable; and
- A clear diagnosis including the appropriate ICD-10 code; the ICD-10 code listed must be consistent with the clinical documentation; and
- Reasonable prognosis, including the member's potential for meaningful and significant progress; and
- Baseline objective measurements (current versions of Standardized Assessments), including a description of the member's current deficits and their severity level which include:
    - Current Standardized Assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores and/or other objective information as appropriate for the member's condition or impairment
    - Standardized Assessments administered must correspond to the delays identified and relate to the long- and short-term goals
    - Standardized Assessments results will not be used as the sole determinant as to the Medical Necessity of the requested initial therapy visit:
    - If the member has a medical condition that prevents them from completing Standardized Assessment(s), alternative could include:
        - The therapist provides in-depth objective clinical information using task analysis to describe the member's deficit area(s) in lieu of Standardized Assessments
        - The therapist should include checklists, caregiver reports or interviews, and clinical observation
- Evaluation reports must include documentation of collaboration with early intervention, head start, and public school programs as applicable. Refer to the ECI section.

Plan of Care

The initial authorization for therapy must also include a plan of care (POC). The POC must be signed and dated by the referring provider (PCP) (MD, DO, PA or NP) or appropriate specialist. Providers must develop a member's POC based on the results of the evaluation. The POC must include all the following:

- Functional or Physical Impairment; and
- Short and long-term therapeutic goals and objectives:
    - Treatment goals should be specific to the member's diagnosed condition or Functional or Physical Impairment
    - Treatment goals must be functional, measurable, attainable and time based
    - Treatment goals must relate to member-specific functional skills;
        - Treatment goals written with targets set for achievements specific to Standardized Assessments benchmarks will not be accepted;

  and
- Treatment frequency, duration, and anticipated length of treatment session(s); and
- Therapeutic methods and monitoring criteria

Group Therapy Documentation Requirements

The documentation must include all of the following:

- Prescribing provider's order for Group Therapy
- Individualized treatment plan that includes frequency and duration of the prescribed Group Therapy and individualized treatment goals
- Name and signature of licensed therapist providing supervision over the Group Therapy session
- Specific treatment techniques utilized during the Group Therapy session and how the techniques will restore function
- Start and stop times for each session
- Group Therapy setting or location
- Number of clients in the group

Requests for Continuation of Therapy Visits

Progress Reports (Summary of Progress)

Intermittent progress reports must demonstrate that the member is making functional progress related to the treatment goals to reflect that continued services are Medically Necessary. Progress reports must include all of the following:

- Start of care date
- Time period covered by the report
- Member's function at the beginning of the progress report period
- Member's current status as compared to evaluation baseline data and the prior progress reports, including objective measures of member performance in functional terms that relate to the treatment goals
- If the member is not making the progress expected, describe any changes in prognosis, POC and goals and why
- Consultations with other professionals or coordination of services, if applicable
- Signature and date of licensed professional responsible for the therapy services
- Signature and date of prescribing physician

Re-Evaluations

Re-evaluations must be completed at least once every six (6) months to support the need for on-going services. Re-evaluations performed more often than once every 6 months should only be completed when the member experiences a Significant Change in Functional Level in their condition or functional status. The documentation must be reflective of this change. Re-evaluations must include current Standardized Assessment scores, age equivalents, percentage of functional delay, criterion referenced scores or other objective information as appropriate for the member's condition or impairment. A signed and dated physician order, less than 45 days old, is needed prior to the completion of a Physical Therapy or Occupational Therapy re-evaluation. The therapy re-evaluation report must include all of the following:

- Date of last therapy evaluation; and
- Number of therapy visits authorized, and number of therapy visits attended; and
- Compliance to home program; and
- Description of the member's current deficits and their severity level documented using objective data; and
- Objective demonstration of the member's progress towards each treatment goal:
  - Using consistent and comparable methods to report progress on long- and short-term treatment goals established
  - For all unmet goals, baseline and current function so that the member's progress towards goals can be measured;

  and
- An updated statement of the prescribed treatment modalities and their recommended frequency/duration; and
- A brief prognosis with clearly established discharge criteria; and
- An updated individualized POC must include updated measurable, functional and time-based goals:
  - The updated POC/progress summary must not be older than 90 days; and
  - If the majority of the long and short-term goals were not achieved, the plan of care must include a description of the barriers or an explanation why the goal(s) needed to be modified or discontinued;

  and
- A revised POC that the treating therapist has not made a meaningful update to support the need for continued services will not be accepted. In addition, the notation of the percentage accuracy towards the member's goals alone is not sufficient to establish a need for continued, Medically Necessary therapy.

Treatment Session Notes

All treatment session notes must include:

- Date of treatment
- Specific treatment(s) provided that match the CPT code(s) billed
- Start and stop time in treatment corresponding to each CPT code billed
- The individual's response to treatment
- Skilled ongoing reassessment of the individual's progress toward the goals
- All progress toward the goals in objective, measurable terms using consistent and comparable methods
- Any problems or changes to the POC
- Member or caregiver involvement in and feedback about home program activities
- Signature and date of the treating provider

Visit Guidelines

Standard Functional Outcome Measures (FOM) used in PT/OT OP-Rehab, such as the following:

FOM	Mild	Moderate	Severe	MCID^
Oswestry Disability Index	0-20%	21-40%	> 40%	10%
Neck Disability Index	≤ 28%	29-48%	> 48%	10%
Disabilities of the Arm, Shoulder & Hand	≤ 25%	26-50%	> 50%	10%
Lower Extremity Functional Scale	80-75%*	74-50%	< 50%	9%

* Higher score = lesser severity

^ MCID = Minimal Clinically Important Difference (The smallest change in an outcome that is clinically meaningful to the patient)

Therapy visits are also evaluated using results from Standardized Assessments based on the following scores:

- Mild (-1 to -1.5 standard deviation from the mean [or a score of 84 to 78])
- Moderate (-1.5 to -2 standard deviation from the mean [or a score of 77 to 71])
- Severe and Profound (>2 standard deviation from the mean [or a score of 70 or below])

If the Physical Therapy/Occupational Therapy provider anticipates that the member has a continued need for Physical Therapy/ Occupational Therapy visits after the duration of the authorization, the provider may follow the re-evaluation process to request additional visits.

For therapy visit guidelines, refer to InterQual® 2022.

Click here to view the InterQual® criteria.

High Frequency Therapy Visits

A request for High Frequency Therapy Visits will be considered with all of the following:

- Letter of medical need from the prescribing provider documenting the client's rehabilitation potential for achieving the goals identified. Therapy provided three or more times a week may be considered when all of the following criteria are met:
  - The client has a medical condition that is rapidly changing
  - The client has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery)
  - The members POC and home program require frequent modification by the licensed therapist;

  and
- Therapy summary documenting all of the following:
  - Purpose of the high frequency therapy requested (e.g., close to achieving a milestone)
  - Identification of the functional skill which will be achieved with high frequency therapy
  - Specific measurable goals related to the high frequency therapy requested and the expected date the goal will be achieved;

  and
- The therapist must provide education and training for the member and responsible caregivers. The therapist must also develop and instruct them in a home exercise program to promote effective carryover of the therapy program and management of safety issues

Discharge Criteria

Discharge criteria includes but is not limited to all of the following (as applicable):

- Treatment goals and objectives have been met
- Functional abilities have become comparable to those of others of the same chronological age and gender
- The desired level of function that has been agreed to by the member and provider has been achieved
- The skill of a physical therapist or occupational therapist or other licensed healthcare professional (within the scope of his/her licensure) is not required
- The member exhibits behavior that interferes with improvement or participation in treatment and efforts to address these factors have not been successful

- In some situations, the member, family, or designated guardian may choose not to participate in treatment, may relocate, or may seek another provider if the therapeutic relationship is not satisfactory. Therefore, discharge is also appropriate in the following situations, provided that the member/client, family, and/or guardian have been advised of the likely outcomes of discontinuation:
  - The member is unwilling to participate in treatment
  - The member exhibits behavior that interferes with improvement or participation in treatment
  - There is a request to be discharged or request continuation of services with another provider
  - The individual is transferred or discharged to another location where ongoing service from the current provider is not reasonably available; efforts should be made to ensure continuation of services in the new locale
- The member is unable to tolerate treatment because of a serious medical, psychological, or other condition

Check the federal, state or contractual requirements that may supersede the Additional Considerations and Coverage Limitations and Exclusions listed below.

Additional Considerations

- Physical Therapy and Occupational Therapy received in the home from a home health agency may be covered under home health care
- Physical Therapy and Occupational Therapy received in the home from an independent therapist that is not affiliated with a home health agency may be covered under Rehabilitation Services – Outpatient Therapy

Coverage Limitations and Exclusions

The following therapy services are not covered:

- Work Hardening and conditioning
- Maintenance Therapy: The services involve non-diagnostic, non-therapeutic, routine, or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed physical or occupational therapist. The establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out is reimbursed as part of a regular treatment visit, not as a separate service
- Assistive and mobility devices to assist with functional abilities and activities of daily living (refer to the Coverage Determination Guideline titled Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements)
- Therapy intended to restore or improve function after a temporary Functional or Physical Impairment that could be reasonably expected to improve without such therapy when the member resumes activities
- Therapy which Duplicate Services that are provided concurrently by any other type of therapy such as Physical Therapy and speech and language therapy, which should provide different treatment goals, plans, and therapeutic modalities
- Therapy for which there is no clinical documentation or POC to support the need for Physical and Occupational Therapy services or continuing therapy

Definitions

Check the federal, state, or contractual definitions that supersede the definitions below.

Duplicate Services: Request for care for the same body part or diagnosis by more than one provider is considered duplicate care. Duplicate care is not Medically Necessary, as the member's condition can improve with care provided under one treatment plan and by one provider.

Individualized Education Program (IEP): A tool defined under federal EPSDT and/or disability regulations that addresses the developmental needs of children with a disability ages 3 through 21 and is intended to ensure such children receive certain prevention, diagnostic and treatment services.

Individualized Family Service Plan (IFSP): A tool defined under federal EPSDT and/or disability regulations that addresses the developmental needs of a child with a disability under the age of 3 and is intended to ensure such children receive certain prevention, diagnostic and treatment services.

Group Therapy: Group Therapy consists of simultaneous treatment to two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief, intermittent personal contact, or

giving the same instructions to two or more clients at the same time, the treatment is recognized as Group Therapy. The physician or therapist involved in Group Therapy services must be in constant attendance, but one-on-one client contact is not required. The following requirements must be met in order to meet the criteria for Group Therapy:

- Prescribing provider's prescription for Group Therapy; and
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements; and
- Each client participating in the group must have an individualized POC for group treatment, including interventions and short-and long-term goals and measurable outcomes; and
- Providers are subject to certification and licensure board standards regarding Group Therapy

Functional or Physical Impairment: A Functional or Physical or physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

High Frequency Therapy Visits: The intensive frequency visits varies based on the individual needs of each member and can include 3 or more visits per week for a limited duration of 8 weeks or less. Use of the intensive frequency visits is considered appropriate for children who have a condition that is changing rapidly, need frequent modification in their plan of care, and require a high frequency of intervention for a limited duration to achieve a new skill or recover function lost due to surgery, Illness, or trauma.

Medically Necessary: Health care services that are all of the following as determined by us or our designee:

- In accordance with *Generally Accepted Standards of Medical Practice*
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms
- Not mainly for your convenience or that of your doctor or other health care provider
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time) are available to Covered Persons on www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.

Occupational Therapy: The practice of Occupational Therapy includes:

- Evaluation and treatment of a person whose ability to perform the tasks of living is threatened or impaired by developmental deficits, sensory impairment, physical injury, or illness
- Using therapeutic goal-directed activities to:
  - Evaluate, prevent, or correct physical dysfunction
  - Maximize function in a person's life

Occupational Therapy uses purposeful activities to obtain or regain skills needed for activities of daily living (ADL) and/or functional skills needed for daily life lost through acute medical condition, acute exacerbation of a medical condition, or chronic medical condition related to injury, disease, or other medical causes. ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility. (AOTA, CMS)

Physical Therapy: The practice of Physical Therapy includes:

- Measurement or testing of the function of the musculoskeletal, or neurological, system
- Rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect
- Treatment, consultative, educational, or advisory services to reduce the incidence or severity of disability or pain to enable, train, or retrain a person to perform the independent skills and activities of daily living

Physical Therapy is limited to the skilled treatment of clients who have acute or acute exacerbation of chronic disorders or chronic medical condition of the musculoskeletal and neuromuscular systems. Physical Therapy may be provided by a physician or physical therapist within their licensed scope of practice. (APTA, CMS)

Standardized Assessments: Standardized Assessments are empirically developed evaluation tools with established statistical reliability and validity. A standardized test is one that requires all test takers to answer the same items/questions in the same way and that is scored in a standard or consistent way, thus making it possible to compare the relative performance of individuals or groups of individuals.

Work Hardening: Treatment programs designed to return a person to work or to prepare a person for specific work.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
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)

CPT Code	Description
97139	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.

CPT Code	Description
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	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
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)/prosthetic(s) encounter, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

HCPCS Code	Description
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes

HCPCS Code	Description
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes
S8990	Physical or manipulative therapy performed for maintenance rather than restoration
S9129	Occupational therapy, in the home, per diem
S9131	Physical therapy; in the home, per diem
S9476	Vestibular rehabilitation program, nonphysician provider, per diem

Revenue Code	Description
Physical Therapy	
0420	Physical therapy
0421	Visit charge
0422	Hourly charge
0423	Group rate
0424	Evaluation or reevaluation
0429	Other physical therapy
0977	Physical therapy
Occupational Therapy	
0430	Occupational therapy
0431	Visit charge
0432	Hourly charge
0433	Group rate
0434	Evaluation or reevaluation
0439	Other occupational therapy
0978	Occupational therapy

References

AbilityLab. Rehabilitation Measures Database. Shirley Ryan AbilityLab 2021; Chicago, IL: https://www.sralab.org/rehabilitation-measures/database. Accessed June 25, 2021.

American Academy of Pediatrics. Council on Children with Disabilities; Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee; Medical Home Initiatives for Children with Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006; 118(1):405-420.

American Occupational Therapy Association. Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. Am J Occup Therapy. 2004; 58(6):663-667.

American Physical Therapy Association. Guidelines for physical therapy documentation of patient/client management. Last updated May 19, 2014. Available at: http://www.apta.org/search.aspx?q=guidelines for physical therapy documentation. Accessed May 24, 2021.

Centers for Medicare & Medicaid Services (CMS). Pub. 100-02, Chapter 15, Sections 220. Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance and Section 230. Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology. September 9, 2014. Available at: http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf. Accessed May 24, 2021.

Guide to Physical Therapist Practice 3.0. Alexandria, VA: American Physical Therapy Association; 2014. Available at: http://guidetoptpractice.apta.org/. Accessed May 24, 2021.

Standards of Practice, the American Occupational Therapy Association. American Journal of Occupational Therapy, December 2015, Vol. 69, 6913410057p1-6913410057p6. http://ajot.aota.org/article.aspx?articleid=2477354. Accessed May 24, 2021.

UnitedHealthcare Insurance Company Generic Certificate of Coverage, 2018.

Guideline History/Revision Information

Date	Summary of Changes
04/01/2022	**Coverage Rationale** • Replaced reference to: *Medical Necessity Clinical Coverage Criteria* ○ "InterQual® *2021*, LOC: Outpatient Rehabilitation & Chiropractic" with "InterQual® *2022*, *Mar. 2022 Release*, LOC: Outpatient Rehabilitation & Chiropractic" *Visit Guidelines* ○ "InterQual® *2021*" with "InterQual® *2022*" **Supporting Information** • Archived previous policy version CS164.G

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.