BSC8.03	Physical Therapy		
Original Policy Date:	August 6, 2010	**Effective Date:**	June 1, 2024
Section:	2.0 Medicine	**Page:**	Page 1 of 15

Policy Statement

This policy includes criteria for coverage approval for both **rehabilitative** physical therapy and **habilitative** physical therapy.

Rehabilitative Physical Therapy
Rehabilitative services are defined as specialized treatments provided to individuals who suffer from either temporary or permanent loss of physical functions due to trauma, illness, congenital anomalies, therapeutic interventions, or loss of a body part, and which are designed to improve or restore the ability to perform Activities of Daily Living (see Policy Guidelines section). These therapeutic services must always have defined goals which can be reached in a reasonable period of time. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both.

I. Rehabilitative physical therapy (PT) services may be considered **medically necessary** when **all** of the following criteria are met:
   A. There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured
   B. There is an expectation of achieving measurable improvement in a reasonable and predictable period of time
   C. Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the individual
   D. Services are delivered by a qualified provider of physical therapy (licensed in the state they are practicing and performing services within their scope of licensure)(see Policy Guidelines section)
   E. Treatment is resulting in demonstrated progress toward measurable goals
   F. Services require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the individual
   G. Physical modalities are performed in conjunction with other skilled treatment procedures

II. Home-based PT may be considered **medically necessary** in selected cases based upon the member's needs in the transition of the member from hospital to home. A member must be homebound to qualify for home-based PT.

III. Duplicate therapy, when individuals receive both physical and occupational therapy, is considered **medically necessary** only if the medical record contains **all** of the following:
   A. Rationale why coordinated multidisciplinary therapy is required
   B. The therapy modalities provided include different treatments and do not duplicate the same treatment (e.g., Physical Therapy vs Occupational Therapy [OT])
   C. The therapy modalities provided have separate treatment plans and goals (e.g., Physical Therapy treatment plan/goals vs Occupational Therapy [OT] treatment plan/goals)

IV. Maintenance programs are considered **not medically necessary**. A maintenance program consists of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional clinically significant functional progress is apparent or expected to occur.

V. Certain types of treatment do not generally require the skills of a qualified provider of PT services and are therefore considered **not medically necessary**. Services may include, but are not limited to:
   A. Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function
   B. **Any** of the following treatments when performed as the solitary treatment or to an individual who presents with no complications:
      1. Cold packs
      2. Contrast baths
      3. Electrical stimulation
      4. General fitness, conditioning and training
      5. Hot packs
      6. Hubbard tank
      7. Hydrocollator
      8. Ice packs
      9. Infrared heat
      10. Massage
      11. Paraffin baths
      12. Pilates
      13. Strapping (as therapy)
      14. Warm water baths
      15. Whirlpool baths

Habilitative Physical Therapy

VI. Per California Senate Bill (SB) 43 (Health and Safety Code 1367.005 and Insurance Code Section 10112.27), "habilitative services" are defined as health care services and devices that help a person keep, learn, or improve skills and functioning for Activities of Daily Living or Instrumental Activities of Daily Living (see Policy Guidelines section). These include common human skills and function that never or only marginally developed because of congenital defect, trauma, illness, therapeutic intervention, or loss of a body part, or skills and functions which are in peril of loss for these reasons. Also, these disabilities are so profound that therapeutic goal setting is not possible and the time to achievement of full or potential function is not predictable.

VII. Habilitative physical therapy services may be considered **medically necessary** when **all** of the following criteria are met:
   A. There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured
   B. There is a written expectation that the therapy will maintain function that is present or will assist in the development of new capabilities, and that discontinuation of therapy will result in loss of capability.
   C. Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the individual
   D. Services are delivered by a qualified provider of physical therapy (licensed in the state they are practicing and performing services within their scope of licensure) (see Policy Guidelines section)
   E. Treatment is resulting in documented improvement, maintenance of capabilities or development of new functions, and is reassessed every six months for continued medical necessity
   F. Services require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the individual
   G. Physical modalities are performed in conjunction with other skilled treatment procedures

VIII. Home-based PT may be considered **medically necessary** in selected cases based upon the member's needs in the transition of the member from hospital to home. A member must be homebound to qualify for home-based PT.

IX. Duplicate therapy, when individuals receive both physical and occupational therapy is considered **medically necessary** only if the medical record contains **all** of the following:
   A. Rationale why coordinated multidisciplinary therapy is required
   B. The therapy modalities provided include different treatments and do not duplicate the same treatment (e.g., Physical Therapy vs Occupational Therapy [OT])
   C. The therapy modalities provided have separate treatment plans and goals (e.g., Physical Therapy treatment plan/goals vs Occupational Therapy [OT] treatment plan/goals)

X. Certain types of treatment do not generally require the skills of a qualified provider of PT services and are therefore considered **not medically necessary**. Services may include, but are not limited to:
   A. Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function
   B. **Any** of the following treatments when performed as the solitary treatment or to an individual who presents with no complications:
      1. Cold packs
      2. Contrast baths
      3. Electrical stimulation
      4. General fitness, conditioning and training
      5. Hot packs
      6. Hubbard tank
      7. Hydrocollator
      8. Ice packs
      9. Infrared heat
      10. Massage
      11. Paraffin baths
      12. Pilates
      13. Strapping (as therapy)
      14. Warm water baths
      15. Whirlpool baths

XI. Habilitative physical therapy is considered **not medically necessary** for **any** of the following:
   A. Member achieves intended normal functioning
   B. Documentation fails to show at least maintenance of original or acquired function
   C. Member can no longer participate in minimal therapy or declines to do so

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Activities of Daily Living

According to the definition provided by the Centers for Medicare and Medicaid Services, "activities of daily living" are defined as:

> "...activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. If a sample person has difficulty performing an activity by himself/herself and without special equipment, or does not perform the activity at all because of health problems, the person is deemed to have a limitation in that activity. The limitation may be temporary or chronic at the time of the survey."

Instrumental Activities of Daily Living

According to the definition provided by the Centers for Medicare and Medicaid Services, "instrumental activities of daily living" are defined as:

> "…activities related to independent living. They include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone. If a sample person has any difficulty performing an activity by himself/herself, or does not perform the activity at all, because of health problems, the person is deemed to have a limitation in that activity. The limitation may be temporary or chronic at the time of the survey."

Plan of Care

The plan of care should include:

- Specific statements of long- and short-term goals
- Measurable objectives
- A reasonable estimate of when the goals will be reached
- The specific procedures, modalities and exercises to be used in treatment
- The frequency and duration of treatment

The plan of care should be updated as the individual's condition changes and documentation should demonstrate that the PT services are contributing to improvement in the individual's condition.

Sessions

A PT session is defined as up to one hour of PT (treatment and/or evaluation) or a combination of up to four PT modalities and/or procedures provided on any given day, and support for the medical necessity for all procedures and modalities is required and subject to Specialty Advisor review. These sessions include, but are not limited to:

- Therapeutic exercise programs, including coordination and resistive exercises, to increase strength, balance, and endurance
- Functional training to restore ability to perform work and/or previous level of daily activity
- Application and fabrication of devices and equipment
- Integumentary repair and protection
- Gait training to restore previous gait pattern or learn the use of a temporary or permanent assistive device or prosthetic
- Modalities utilizing mechanical, electrical and/or thermal properties
- Manual therapy techniques
- Individual and family education in home exercise programs

Discontinuation of Rehabilitative Physical Therapy Services

Indications for discontinuation of PT include **any** of the following:

- Documentation that the individual has reached maximum therapeutic benefit from PT services
- Individual has achieved stated goals
- No documented evidence of clinically significant measurable improvement during the last three treatments (unless valid medical reasons are provided to explain a temporary plateau in progress)
- Medical condition prevents therapy
- Individual refuses treatment
- Individual's expected restoration potential would be insignificant in relation to the extent and duration of the PT services required to achieve such potential

Evaluation and Management Codes

In alignment with Centers for Medicare & Medicaid Services (CMS) and National Correct Coding Initiative (NCCI), Current Procedural Terminology (CPT) Evaluation and Management codes (CPT-4 99201 through 99499) are not separately billable by physical therapists in independent practice.

Coding

See the Codes table for details.

Description

Physical therapy (PT) is the treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, a patient's ability to go through the functional activities of daily living, and on alleviating pain.

Treatment may include active and passive modalities and procedures using a variety of means and techniques based upon biomechanical and neurophysiological principles.

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

- N/A

Rationale

A review of the published peer-reviewed literature identifies few clinical trials that assess the effect of individual physical therapy modalities or procedures in the treatment of specific medical conditions. Due to the evidence evaluating multiple modalities during treatment, it is difficult to determine the efficacy of individual modalities for specific conditions.

The American Physical Therapy Association (APTA) published criteria for standards of practice for physical therapy.[1]

> The physical therapist establishes a plan of care and manages the needs of the patient/client based on the examination, evaluation, diagnosis, prognosis, goals, and outcomes of the planned interventions for identified impairments in body structures and function, activity limitations, and participation restrictions.

The plan of care criteria includes:

- Examination, evaluation, diagnosis, and prognosis
- Goals and outcomes that are reasonable and attainable
- Proposed intervention, including frequency and duration
- Documentation that is dated and appropriately authenticated by the physical therapist who established the plan of care

The Standards of Practice note that the interventions are "consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care." The following criteria apply to the interventions:

- Is based on the examination, evaluation, diagnosis, prognosis, and plan of care
- Is provided under the ongoing direction and supervision of the physical therapist
- Is provided in such a way that directed and supervised responsibilities are commensurate with the qualifications and the legal limitations of the physical therapist assistant
- Is altered in accordance with changes in response or status
- Is provided at a level that is consistent with current physical therapy practice
- Is interdisciplinary when necessary to meet the needs of the patient/client
- Documentation of the intervention is consistent with the Guidelines: Physical Therapy Documentation of Patient/Client Management
- Is dated and appropriately authenticated by the physical therapist or, when permissible by law, by the physical therapist assistant

The following criteria apply to discharge and discontinuation of services:

- The physical therapist discharges the patient/client from PT services when the anticipated goals or expected outcomes for the patient/client have been achieved
- The physical therapist discontinues intervention when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy

Summary of Evidence

Physical therapy should be individualized with specific diagnosis-related measurable goals that are reevaluated throughout the treatment program. The therapy, delivered by a qualified provider of physical therapy, should be expected to result in significant improvement in the patient's condition.

References

1. American Physical Therapy Association (APTA). Criteria for Standards of Practice for Physical Therapy. BOD S03-06-16-38. Updated 4/15/14. Accessed on March 19, 2020 from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/CriteriaStandardsPractice.pdf#search=%22Criteria for Standards of Practice%22.
2. American Physical Therapy Association (APTA). Standards of Practice for Physical Therapy. HOD S06-20-35-29. Updated 08/12/2020. Accessed on May 21, 2024 from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/StandardsPractice.pdf#search=%22Criteria for Standards of Practice%22.
3. California Legislative Information. Health and Safety Code – HSC. Division 2. Licensing Provisions [1200-1796.70]. Chp. 2.2 Health Care Service Plans [1340-1399.864]. 1367.005 1975:Ch.941, amended Jan 1, 2017. Accessed on May 21, 2024 from https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=2.&title=&part=&chapter=2.2.&article=5.
4. California Legislative Information. Insurance Code – INS. Division 2. Classes of Insurance [1880 - 12880.6]. Part 2. Life and Disability Insurance [10110 - 11549]. Chp 1, The Contract [10110

- 10198.10]. 10112.27 1935:Ch.145, amended Jan 1, 2017. Accessed on May 21, 2024 from https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=INS&division=2.&title=&part=2.&chapter=1.&article=1.

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Initial physical therapy evaluation with documented goals
  - Progress letters
  - Daily treatment notes including flow sheets
  - For additional treatments/extension of therapy, documentation of the need for the additional sessions as well as any new goals if applicable

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	97010	Application of a modality to 1 or more areas; hot or cold packs
	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

Type	Code	Description
	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
	97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
	97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
	97139	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)
	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
	97545	Work hardening/conditioning; initial 2 hours
	97597	Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less
	97598	Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
	97602	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
	97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes

Type	Code	Description
	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
	97799	Unlisted physical medicine/rehabilitation service or procedure
HCPCS	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
	G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
	G0329	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
	S8990	Physical or manipulative therapy performed for maintenance rather than restoration

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
08/06/2010	New Policy Adoption
05/18/2012	Policy revision with position change
05/25/2012	Administrative Review
05/29/2015	Policy revision with position change
02/01/2016	Policy statement clarification
06/01/2016	Policy revision without position change
06/01/2017	Policy revision without position change
12/01/2017	Policy revision without position change
06/01/2018	Policy revision with position change
04/01/2019	Policy revision without position change
05/01/2020	Annual review. No change to policy statement. References updated.
05/01/2021	Annual review. No change to policy statement.
06/01/2022	Annual review. No change to policy statement.
06/01/2023	Annual review. Policy statement and guidelines updated.
06/01/2024	Annual review. No change to policy statement.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent

therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	**AFTER**
Physical Therapy BSC8.03 **Policy Statement:** This policy includes criteria for coverage approval for both **rehabilitative** physical therapy and **habilitative** physical therapy. **Rehabilitative Physical Therapy** Rehabilitative services are defined as specialized treatments provided to individuals who suffer from either temporary or permanent loss of physical functions due to trauma, illness, congenital anomalies, therapeutic interventions, or loss of a body part, and which are designed to improve or restore the ability to perform Activities of Daily Living (see Policy Guidelines section). These therapeutic services must always have defined goals which can be reached in a reasonable period of time. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. I. Rehabilitative physical therapy (PT) services may be considered **medically necessary** when **all** of the following criteria are met: A. There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured B. There is an expectation of achieving measurable improvement in a reasonable and predictable period of time C. Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the individual D. Services are delivered by a qualified provider of physical therapy (licensed in the state they are practicing and performing services within their scope of licensure)(see Policy Guidelines section) E. Treatment is resulting in demonstrated progress toward measurable goals	**Physical Therapy BSC8.03** **Policy Statement:** This policy includes criteria for coverage approval for both **rehabilitative** physical therapy and **habilitative** physical therapy. **Rehabilitative Physical Therapy** Rehabilitative services are defined as specialized treatments provided to individuals who suffer from either temporary or permanent loss of physical functions due to trauma, illness, congenital anomalies, therapeutic interventions, or loss of a body part, and which are designed to improve or restore the ability to perform Activities of Daily Living (see Policy Guidelines section). These therapeutic services must always have defined goals which can be reached in a reasonable period of time. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. I. Rehabilitative physical therapy (PT) services may be considered **medically necessary** when **all** of the following criteria are met: A. There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured B. There is an expectation of achieving measurable improvement in a reasonable and predictable period of time C. Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the individual D. Services are delivered by a qualified provider of physical therapy (licensed in the state they are practicing and performing services within their scope of licensure)(see Policy Guidelines section) E. Treatment is resulting in demonstrated progress toward measurable goals

POLICY STATEMENT (No changes)	
BEFORE	**AFTER**
F. Services require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the individual G. Physical modalities are performed in conjunction with other skilled treatment procedures	F. Services require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the individual G. Physical modalities are performed in conjunction with other skilled treatment procedures
II. Home-based PT may be considered **medically necessary** in selected cases based upon the member's needs in the transition of the member from hospital to home. A member must be homebound to qualify for home-based PT.	II. Home-based PT may be considered **medically necessary** in selected cases based upon the member's needs in the transition of the member from hospital to home. A member must be homebound to qualify for home-based PT.
III. Duplicate therapy, when individuals receive both physical and occupational therapy, is considered **medically necessary** only if the medical record contains **all** of the following: A. Rationale why coordinated multidisciplinary therapy is required B. The therapy modalities provided include different treatments and do not duplicate the same treatment (e.g., Physical Therapy vs Occupational Therapy [OT]) C. The therapy modalities provided have separate treatment plans and goals (e.g., Physical Therapy treatment plan/goals vs Occupational Therapy [OT] treatment plan/goals)	III. Duplicate therapy, when individual receive both physical and occupational therapy, is considered **medically necessary** only if the medical record contains **all** of the following: A. Rationale why coordinated multidisciplinary therapy is required B. The therapy modalities provided include different treatments and do not duplicate the same treatment (e.g., Physical Therapy vs Occupational Therapy [OT]) C. The therapy modalities provided have separate treatment plans and goals (e.g., Physical Therapy treatment plan/goals vs Occupational Therapy [OT] treatment plan/goals)
IV. Maintenance programs are considered **not medically necessary**. A maintenance program consists of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional clinically significant functional progress is apparent or expected to occur.	IV. Maintenance programs are considered **not medically necessary**. A maintenance program consists of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional clinically significant functional progress is apparent or expected to occur.
V. Certain types of treatment do not generally require the skills of a qualified provider of PT services and are therefore considered **not medically necessary**. Services may include, but are not limited to: A. Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function	V. Certain types of treatment do not generally require the skills of a qualified provider of PT services and are therefore considered **not medically necessary**. Services may include, but are not limited to: A. Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function

POLICY STATEMENT (No changes)	
BEFORE	**AFTER**
B. **Any** of the following treatments when performed as the solitary treatment or to a individual who presents with no complications: 1. Cold packs 2. Contrast baths 3. Electrical stimulation 4. General fitness, conditioning and training 5. Hot packs 6. Hubbard tank 7. Hydrocollator 8. Ice packs 9. Infrared heat 10. Massage 11. Paraffin baths 12. Pilates 13. Strapping (as therapy) 14. Warm water baths 15. Whirlpool baths	B. **Any** of the following treatments when performed as the solitary treatment or to an individual who presents with no complications: 1. Cold packs 2. Contrast baths 3. Electrical stimulation 4. General fitness, conditioning and training 5. Hot packs 6. Hubbard tank 7. Hydrocollator 8. Ice packs 9. Infrared heat 10. Massage 11. Paraffin baths 12. Pilates 13. Strapping (as therapy) 14. Warm water baths 15. Whirlpool baths
Habilitative Physical Therapy VI. Per California Senate Bill (SB) 43 (Health and Safety Code 1367.005 and Insurance Code Section 10112.27), "habilitative services" are defined as health care services and devices that help a person keep, learn, or improve skills and functioning for Activities of Daily Living or Instrumental Activities of Daily Living (see Policy Guidelines section). These include common human skills and function that never or only marginally developed because of congenital defect, trauma, illness, therapeutic intervention, or loss of a body part, or skills and functions which are in peril of loss for these reasons. Also, these disabilities are so profound that therapeutic goal setting is not possible and the time to achievement of full or potential function is not predictable.	**Habilitative Physical Therapy** VI. Per California Senate Bill (SB) 43 (Health and Safety Code 1367.005 and Insurance Code Section 10112.27), "habilitative services" are defined as health care services and devices that help a person keep, learn, or improve skills and functioning for Activities of Daily Living or Instrumental Activities of Daily Living (see Policy Guidelines section). These include common human skills and function that never or only marginally developed because of congenital defect, trauma, illness, therapeutic intervention, or loss of a body part, or skills and functions which are in peril of loss for these reasons. Also, these disabilities are so profound that therapeutic goal setting is not possible and the time to achievement of full or potential function is not predictable.
VII. Habilitative physical therapy services may be considered **medically necessary** when **all** of the following criteria are met:	VII. Habilitative physical therapy services may be considered **medically necessary** when **all** of the following criteria are met:

POLICY STATEMENT (No changes)	
BEFORE	**AFTER**
A. There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured B. There is a written expectation that the therapy will maintain function that is present or will assist in the development of new capabilities, and that discontinuation of therapy will result in loss of capability. C. Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the individual D. Services are delivered by a qualified provider of physical therapy (licensed in the state they are practicing and performing services within their scope of licensure) (see Policy Guidelines section) E. Treatment is resulting in documented improvement, maintenance of capabilities or development of new functions, and is reassessed every six months for continued medical necessity F. Services require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the individual G. Physical modalities are performed in conjunction with other skilled treatment procedures	A. There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured B. There is a written expectation that the therapy will maintain function that is present or will assist in the development of new capabilities, and that discontinuation of therapy will result in loss of capability. C. Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the individual D. Services are delivered by a qualified provider of physical therapy (licensed in the state they are practicing and performing services within their scope of licensure) (see Policy Guidelines section) E. Treatment is resulting in documented improvement, maintenance of capabilities or development of new functions, and is reassessed every six months for continued medical necessity F. Services require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the individual G. Physical modalities are performed in conjunction with other skilled treatment procedures
VIII. Home-based PT may be considered **medically necessary** in selected cases based upon the member's needs in the transition of the member from hospital to home. A member must be homebound to qualify for home-based PT.	VIII. Home-based PT may be considered **medically necessary** in selected cases based upon the member's needs in the transition of the member from hospital to home. A member must be homebound to qualify for home-based PT.
IX. Duplicate therapy, when individuals receive both physical and occupational therapy is considered **medically necessary** only if the medical record contains **all** of the following: A. Rationale why coordinated multidisciplinary therapy is required B. The therapy modalities provided include different treatments and do not duplicate the same treatment (e.g., Physical Therapy vs Occupational Therapy [OT])	IX. Duplicate therapy, when individuals receive both physical and occupational therapy is considered **medically necessary** only if the medical record contains **all** of the following: A. Rationale why coordinated multidisciplinary therapy is required B. The therapy modalities provided include different treatments and do not duplicate the same treatment (e.g., Physical Therapy vs Occupational Therapy [OT])

POLICY STATEMENT (No changes)	
BEFORE	**AFTER**
C. The therapy modalities provided have separate treatment plans and goals (e.g., Physical Therapy treatment plan/goals vs Occupational Therapy [OT] treatment plan/goals)	C. The therapy modalities provided have separate treatment plans and goals (e.g., Physical Therapy treatment plan/goals vs Occupational Therapy [OT] treatment plan/goals)
X. Certain types of treatment do not generally require the skills of a qualified provider of PT services and are therefore considered **not medically necessary**. Services may include, but are not limited to: A. Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function B. **Any** of the following treatments when performed as the solitary treatment or to a individual who presents with no complications: 1. Cold packs 2. Contrast baths 3. Electrical stimulation 4. General fitness, conditioning and training 5. Hot packs 6. Hubbard tank 7. Hydrocollator 8. Ice packs 9. Infrared heat 10. Massage 11. Paraffin baths 12. Pilates 13. Strapping (as therapy) 14. Warm water baths 15. Whirlpool baths	X. Certain types of treatment do not generally require the skills of a qualified provider of PT services and are therefore considered **not medically necessary**. Services may include, but are not limited to: A. Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function B. **Any** of the following treatments when performed as the solitary treatment or to an individual who presents with no complications: 1. Cold packs 2. Contrast baths 3. Electrical stimulation 4. General fitness, conditioning and training 5. Hot packs 6. Hubbard tank 7. Hydrocollator 8. Ice packs 9. Infrared heat 10. Massage 11. Paraffin baths 12. Pilates 13. Strapping (as therapy) 14. Warm water baths 15. Whirlpool baths
XI. Habilitative physical therapy is considered **not medically necessary** for **any** of the following: A. Member achieves intended normal functioning B. Documentation fails to show at least maintenance of original or acquired function C. Member can no longer participate in minimal therapy or declines to do so	XI. Habilitative physical therapy is considered **not medically necessary** for **any** of the following: A. Member achieves intended normal functioning B. Documentation fails to show at least maintenance of original or acquired function C. Member can no longer participate in minimal therapy or declines to do so