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.

Rehabilitative physical therapy (PT) services may be considered medically necessary when all of the following criteria are met:

- There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured
- There is an expectation of achieving measurable improvement in a reasonable and predictable period of time
- Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the patient
- 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)
- Treatment is resulting in demonstrated progress toward measurable goals
- 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 patient
- Physical modalities are performed in conjunction with other skilled treatment procedures

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.

Duplicate therapy is considered not medically necessary. When patients receive both physical and occupational therapy, the therapies should provide different treatments and not duplicate the same treatment. They must also have separate treatment plans and goals.

Maintenance programs are considered not medically necessary. A maintenance program consists of activities that preserve the patient'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.

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:

- Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function
• **Any** of the following treatments when performed as the solitary treatment or to a patient who presents with no complications: massage; general fitness, conditioning and training; Pilates; hot packs; strapping (as therapy); hydrocollator; infrared heat; electrical stimulation; whirlpool baths; paraffin baths; Hubbard tank; cold packs; ice packs; warm water baths; and contrast baths

**Habilitative Physical Therapy**

Per California Senate Bill (SB) 43 (Health and Safety Code 1367.005 and Insurance Co de 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 services may be considered **medically necessary** when all of the following criteria are met:

- There is a formal physical therapy evaluation with specific and functional diagnosis-related goals that can be objectively measured
- 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.
- Specific, effective, and reasonable treatment is provided for the diagnosis and physical condition of the patient
- 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)
- Treatment is resulting in documented improvement, maintenance of capabilities or development of new functions, and is reassessed every six months for continued medical necessity
- 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 patient
- Physical modalities are performed in conjunction with other skilled treatment procedures

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.

Duplicate therapy is considered **not medically necessary**. When patients receive both physical and occupational therapy, the therapies should provide different treatments and not duplicate the same treatment. They must also have separate treatment plans and goals.

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:

- Passive range of motion (ROM) treatment, which is not related to restoration of a specific loss of function
- **Any** of the following treatments when performed as the solitary treatment or to a patient who presents with no complications: massage; general fitness, conditioning and training; Pilates; hot packs; strapping (as therapy); hydrocollator; infrared heat; electrical stimulation; whirlpool baths; paraffin baths; Hubbard tank; cold packs; ice packs; warm water baths; and contrast baths

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

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 patient's condition changes and documentation should demonstrate that the PT services are contributing to improvement in the patient'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 prosthesis
• Modalities utilizing mechanical, electrical and/or thermal properties
• Manual therapy techniques
• Patient 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 patient has reached maximum therapeutic benefit from PT services
• Patient 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
• Patient refuses treatment
• Patient'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.

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

**Documentation for Clinical Review**

Please provide the following documentation (if/when requested):
- History and physical and/or consultation notes including:
  - Initial physical therapy evaluation with documented goals
  - Progress letters
  - Daily treatment notes including flow sheets

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

**MN/NMN**

The following services may be considered medically necessary when policy criteria are met. Services may be considered not medically necessary when policy criteria are not met.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>All</td>
<td>Any Applicable Physical Therapy CPT Codes</td>
</tr>
<tr>
<td>HCPCS</td>
<td>All</td>
<td>Any Applicable Physical Therapy HCPCS codes</td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>ICD-10 Diagnosis</td>
<td>All</td>
<td>All Diagnoses</td>
</tr>
</tbody>
</table>

**NMN**

The following services may be considered not medically necessary.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td>S8990</td>
<td>Physical or manipulative therapy performed for maintenance rather than restoration</td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>ICD-10 Diagnosis</td>
<td>All</td>
<td>All Diagnoses</td>
</tr>
</tbody>
</table>

**Policy History**

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

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/06/2010</td>
<td>New Policy Adoption</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>05/18/2012</td>
<td>Policy revision with position change</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>05/25/2012</td>
<td>Administrative Review</td>
<td>Administrative Review</td>
</tr>
<tr>
<td>05/29/2015</td>
<td>Policy revision with position change</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>02/01/2016</td>
<td>Policy statement clarification</td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>
Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**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 (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. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

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.