

## Contractor Information

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[Cahaba Government Benefit Administrators,® LLC - Midwest](#)

**Contractor Number** [back to top](#)

00011

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RHHI

## LCD Information

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L23604

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Physical Therapy - Home Health

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**AMA CPT / ADA CDT Copyright Statement** [back to top](#)

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**CMS National Coverage Policy** [back to top](#)

- Social Security Act, Title XVIII, section 1834 (K)(5) incorporates the provisions in the Balanced Budget Act (BBA) of 1997; Section 4541 (a)(2) to require payment under a prospective payment system of outpatient rehabilitation services
- Social Security Act, Title XVIII, section 1835 (a)(C) establishes conditions for payment of claims to institutional providers of outpatient

therapy services, including certification and plan of treatment requirements

- Social Security Act, Title XVIII, sections 1861(g)(p)(s)(u), and (cc)(II) establish definitions for services, institutions, and other Medicare terms
- Social Security Act, Title XVIII, section 1862(a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and medically necessary
- Social Security Act, Title XVIII, section 1862(a)(7) excludes routing physical examinations
- 42 Code of Federal Regulations (42CFR) Parts:
  - 409 includes the definition of 'reasonable and necessary' therapy services that applies to both Part A and Part B services
  - 411 describes those specific services excluded from Medicare or that are subject to limitations on payment
  - 420 describe specific Medicare program integrity requirements to prevent fraud and abuse. It also sets forth appeal rights of providers.
  - 421 identifies the activities required of the fiscal intermediaries and carriers that process Medicare claims
  - 424 describes the conditions for Medicare payment, including those governing Part B outpatient physical therapy services. In particular, it sets forth certification and plan of treatment requirements
  - 484 includes the personnel qualifications that Medicare requires for identification as a physical therapist or a physical therapy assistant
- Medicare General Information, Eligibility, and Entitlement Manual (Pub 100-1), Chapter 4, Section 30
- Medicare Benefit Policy, Chapter 7, Sections 30.4, 40, and 40.2
- Medicare Claims Processing Manual (Pub 100-4), Chapter 10
- Medicare National Coverage Determinations (NCDs) Manual (Pub 100-3), Chapter 1, Sections 10.2, 20.2, 30.1, 30.1.1, 30.5, 150.1, 150.4, 150.5, 150.8, 160.2, 160.3, 160.7, 160.7.1, 160.12, 160.13, 160.15, 160.16, 170.1, 170.1.1, 270.1.1, 270.6, 240.3, 270.4, 280.13, and 280.3.

- CMS Manual System, Publication 100-08, Medicare Program Integrity, Transmittal 63, Change Request 3010, dated January 23, 2004
- CMS Manual System, Publication 100-08, Medicare Program Integrity, Transmittal AB-02-078, Change Request 2083, dated May 29, 2002
- CMS Manual System, Publication 100-04, Medicare Claims Processing, Transmittal 676, dated September 16, 2005, Change Request 4057

### **Primary Geographic Jurisdiction** [back to top](#)

Colorado  
District of Columbia  
Delaware  
Iowa  
Kansas  
Maryland  
Missouri - Entire State  
Montana  
North Dakota  
Nebraska  
Pennsylvania  
South Dakota  
Utah  
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Wyoming

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Region VII

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For services performed on or after 04/01/2007

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### **GENERAL THERAPY GUIDELINES**

Physical therapy services are part of a constellation of rehabilitative services designed to improve or restore physical functioning following disease, injury, or loss of a body part. Physical therapists use the clinical history, systems review, physical examination, and a variety of evaluations to characterize individuals with impairments, functional limitations and disabilities. Impairments, functional limitations, and disabilities thus identified are then addressed by the design and implementation of a therapeutic intervention tailored to the specific needs of the individual patient. The specific interventions most commonly utilized are exercise, gait and balance training, heat, cold, electricity, ultraviolet light, ultrasound, hydrotherapy, and massage to improve circulation, strengthen muscles, maintain or restore motion, and train or retrain an individual to perform the activities of daily living.

#### *Indications*

- The patient must be under the care of and referred for therapy services by a physician who is a doctor of medicine, osteopathy, or podiatric medicine (a doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).
- Physical therapy services are covered, provided such services are of a level of complexity and sophistication, or the patient's condition is such that the services can be safely and effectively performed only by a licensed qualified physical therapist or licensed physical therapist assistant (LPTA). Services normally considered to be a routine part of nursing care are not covered as physical therapy (e.g., turning patients to prevent pressure injuries or walking a patient in the hallway postoperatively).

- Physical therapy is only covered when it is rendered under an active written treatment plan, which is certified/approved by the individual's physician, and must be reasonable and necessary to the treatment of the individual's illness or injury. The plan of treatment should address specific therapeutic goals for which modalities and procedures are planned out specifically in terms of type, frequency, and duration. The therapist must document the patient's functional limitations and therapeutic short and long term goals in terms that are objective and measurable.
- In order for the plan of care to be covered, it must address a condition for which physical therapy is an accepted method of treatment, as defined by standards of medical practice. There must be an expectation that the condition will improve significantly in a reasonable and generally predictable period of time based on the physician's assessment of the patient's rehabilitation potential, after any needed consultation with the qualified physical therapist.
- The goal for a patient is to return to the highest level of function realistically attainable and within the context of the disability. Services of skilled therapists for the purpose of teaching the patient or the patient's family or caregivers necessary techniques, exercises, or precautions are covered to the extent that they are reasonable and necessary to treat illness or injury. However, the skills of the therapist may not necessarily be required to attain this goal but may be required initially to ensure safety, proper modality performance, etc. then transferring their care to a caregiver and home exercise plan (HEP).
- The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's condition, those activities require the skills of the therapist to manage non-skilled services.
- Utilization guidelines (i.e. number of visits) mentioned throughout the LCD, serve as only a guideline and **DO NOT** imply coverage or non-coverage of a service therein. Services must be reasonable and necessary for each individual visit, as supported by the plan of treatment and the therapists' documentation, based on an assessment of each beneficiary's individual care needs.

The design of a maintenance regimen/HEP required to delay or minimize muscular and functional deterioration in patients suffering from a chronic

disease may be considered reasonable and necessary. Limited services may be considered reasonable and necessary to establish and assist the patient and/or caregiver with the implementation of a rehabilitation maintenance program/HEP. Generally, no more than 4 visits to instruct in a maintenance program/HEP are considered medically necessary without supporting documentation.

- Rehabilitation Services for Vision Impairment: the coverage criteria and definition of rehabilitation services for vision impairment (Low Vision) is found in Transmittal AB-02-078, Change Request 2083, dated 5/28/02.
- This LCD is based on impairments of structure/function and functional limitations. While the pathophysiology is an important factor, the purpose of this LCD is to show the specific functional limitation of the patient. The “ICD-9 Codes that Support Medical Necessity” Section of this LCD is meant to include ‘functional’ diagnoses. The functional diagnoses, not necessarily the clinical diagnoses, may support coverage.

### *Limitations*

- Physical therapy is not covered when the documentation fails to support that the functional ability or medical condition was impaired to the degree that it required the skills of a therapist. Except in cases of maintenance therapy, physical therapy is not covered when the documentation indicates the patient has not reached the therapy goals and is not making significant improvement or progress, and/or is unable to participate and/or benefit from skilled intervention or refused to participate.
- Physical therapy is not covered when the documentation indicates that a patient has attained the therapy goals or has reached the point where no further significant practical improvement can be expected. The skills of the physical therapist are not required to maintain function.
- Enhancing already evident/existing functional status is not reasonable and necessary; therefore noncovered.
- Physical therapy is not covered when a patient suffers a temporary loss or reduction of function and could reasonably be expected to improve over time without the services of the physical therapist. It is necessary to determine if individual therapy services are skilled, and whether, in view of the patient’s overall condition, skilled management of the services provided is needed although many or all of the specific services needed to treat the illness or injury do not require the skills of a therapist. The key issue is whether the skills of a therapist are needed to treat the illness or

injury, or whether non-skilled personnel can carry out the services. For example, the patient recovering from a short hospital stay for pneumonia may need only time and the gradual resumption of normal physical activities to regain their strength and function.

- Physical therapy services provided routinely to identify patients who might need or benefit from physical therapy intervention are not covered.
- Physical therapy services, which are duplicative of other concurrent rehabilitation services, are not covered.
- Physical therapy visits would not be routinely covered on a daily basis through discharge. Normally, visit frequency would decrease as the patient's condition improves.
- Services that are related solely to specific employment opportunities (i.e., on-the-job training, work skills, or work settings) are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are not covered.
- The education component of treatment should begin at the start of care and continue until discharge. Continued visits to exclusively teach the HEP are not covered in the absence of documentation supporting ongoing education throughout the patient's entire course of treatment.
- This local coverage determination (LCD) does not address any wound debridement services that may be provided by the physical therapist

The following services are **non-covered** (not reasonable and necessary) for physical therapists:

- **CPT 0029T** - Treatment(s) for incontinence, pulsed magnetic neuromodulation, per day
- **CPTs 90901 and 90902** - Biofeedback training is not a covered service in the home setting. Refer to CMS' NCD 30.1, which states biofeedback services are only covered in the outpatient setting.
- **CPT 97001 and 97002** - An evaluation by a therapist is non-covered when the evaluation is for a non-covered service. For example, pre-surgical evaluations for the purpose of teaching a HEP and giving assistive device instruction prior to a scheduled surgical procedure are not covered. This may include but not limited to crutch-walking, donning/doffing of post-surgical immobilizers and/or splints, and performing strengthening exercises
- **CPT 97150** - Group therapy is not a covered service in the home health

setting

- **CPT 97532** - Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
- **CPT 97533** - Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
- **CPT 97545** - Work hardening/conditioning; initial 2 hours
- **CPT 97546** - Each additional hour  
Services for CPT 97545 and 97546 are related solely to specific work skills and will be considered not reasonable and necessary for the diagnosis or treatment of an illness or injury
- **CPT 97781** - With electrical stimulation
- **CPT 97810** - Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- **CPT 97811** - Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
- **HCPCS G0237** - Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (including monitoring)
- **HCPCS G0238** - Therapeutic procedures to improve respiratory function, other than described by HCPCS G0237, one-on-one, face-to-face, per 15 minutes (including monitoring)
- **HCPCS G0239** - Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (including monitoring)
- **HCPCS G0282** - Electrical stimulation (unattended), to one or more areas, for wound care other than described in HCPCS G0281
- **Electrical stimulation modalities (refer to CMS' NCD Section 270 for Wound Treatment) for the treatment of:**
  - Stage I or stage II wounds

- Electrical stimulation and electromagnetic therapy for the treatment of wounds will not be covered as an initial treatment modality for chronic stage III or stage IV wounds.
  - Continued treatment with electrical stimulation and electromagnetic stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Measurable signs of healing include a decrease in wound size either in surface area or volume, decrease in amount of exudates and decrease in amount of necrotic tissue.
  - Wounds that demonstrate a 100% epithelialized wound bed
  - Patients in the home setting, as unsupervised use by patients in the home has not been found to be medically reasonable and necessary.
  - Facial nerve paralysis, commonly known as Bell's Palsy (considered investigational).
  - Motor function disorders such as multiple sclerosis (considered investigational)
  - Cerebral vascular accidents or strokes, when determined there is no potential for restoration of function
- **Temporomandibular Joint (TMJ) Pain**  
Currently the medical literature provides no consensus on the requirement of a skilled therapist to perform therapy techniques for TMJ pain/ disorders.
  - **Pelvic Floor Dysfunction**  
Due to the lack of peer-reviewed evidence concerning the effect on patient health outcomes, skilled therapy modalities (e.g. ultrasound, electrical stimulation, soft tissue mobilization, therapeutic exercise) for the treatment of pelvic floor dysfunction are considered investigational and thus non-covered. Pelvic floor dysfunction is a global term which may include, but not limited to the following conditions:
    - Pelvic floor congestion
    - Pelvic floor pain not of spinal origin
    - Hypersensitive clitoris
    - Prostatitis
    - Cystourethrocele
    - Enterocoele
    - Rectocoele
    - Fecal incontinence

Vulvodynia  
Dyspareunia  
Pelvic floor relaxation disorders

**Note:** Urinary incontinence is not included in this list, and certain treatment modalities may be covered, per NCD guidelines. NCDs are located on CMS's Web site, at: [www.cms.hhs.gov](http://www.cms.hhs.gov).

- **Miscellaneous Services** (This list is not all-inclusive)
  - Constraint Induced Movement Therapy (CIMT)
  - Loop reflex training
  - 'Metronome' therapy
  - Infrared therapy for treatment of diabetic and non-diabetic peripheral sensory neuropathy, wounds and ulcers, and similar related conditions, including symptoms such as pain arising from these conditions. —As of October 24, 2006, CMS has determined that there is sufficient evidence to conclude that the use of infrared devices is not reasonable and necessary for treatment of Medicare beneficiaries for diabetic and non-diabetic peripheral sensory neuropathy, wounds and ulcers, and similar related conditions, including symptoms such as pain arising from these conditions. The use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is not covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of skin and/or subcutaneous tissues in Medicare beneficiaries. Refer to CMS' NCD 270.6, "Infrared Therapy Devices," for additional information.
  - Scar massage
  - Driving assessments
  - Assessments for non-covered items (e.g. DME products)

### *Special Considerations*

#### **Maintenance Therapy**

Where repetitive services that are required to maintain function involve the use of complex and sophisticated procedures, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services.

If the judgment and skill of a physical therapist is required to safely and effectively treat the illness or injury, the services may be covered as physical therapy services. For additional information refer to CMS' Publication 100-2, Chapter 7, Section 402.2E, at: [www.cms.hhs.gov](http://www.cms.hhs.gov)

- The establishment of a maintenance program is a skilled physical therapy service where the specialized knowledge and judgment of a qualified physical therapist is required for the program to be safely carried out and the treatment of the physician to be achieved:
  - The design of a maintenance regimen required to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease may be considered reasonable and necessary
  - Limited services may be considered reasonable and necessary to establish and assist the patient and/or their caregiver with the implementation of a safe and effective rehabilitation maintenance program
  - Infrequent re-evaluations required to assess the patient's condition and adjust the program may be considered reasonable and necessary
  - In the case where a patient has been under a restorative physical therapy program and reaches a point where no further improvement is likely, a maintenance program would also be appropriate. However, the therapist should have already designed the program and done the appropriate teaching prior to the time the patient shows no further potential to improve. If the maintenance program were not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would not be covered. Periodic re-evaluations by the physical therapist may be the only required skilled service after a maintenance program has been established
- The skills of the physical therapist must be necessary to perform a safe and effective maintenance program.
  - Example: Where there is an unhealed, unstable fracture that requires regular exercise to maintain function until the fracture heals, the skills of a physical therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.
- It is not reasonable and necessary for a physical therapist to perform or

supervise maintenance programs that do not require the skills of a physical therapist. These situations include:

- Services related to activities for the general good and welfare of patients (i.e., general exercises to promote overall fitness and flexibility)
- Repetitive exercises to maintain gait or maintain strength and endurance, and assisted walking, such as that provided in support for feeble and unstable patients
- Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities
- Maintenance therapies after the patient has achieved therapeutic goals

### **Vestibular Rehabilitation**

Vestibular rehabilitation is a constellation of individualized rehabilitative services used in the management of vestibular disorders. Appropriate selection of patients for vestibular rehabilitation is essential to its success and thus its coverage. Although dizziness is often a core complaint, it is not the functional deficit by which patients are selected for vestibular rehabilitation. Coverage for vestibular rehabilitation will be for those patients with documented vestibular hypofunction or with Benign Paroxysmal Positional Vertigo (BPPV).

The goals of vestibular rehabilitation for patients with vestibular hypofunction, although individualized, should be targeted toward enabling the patient to see clearly during head movement; improving static balance and improving dynamic postural stability. The goals of vestibular rehabilitation for patients with BPPV should be targeted toward achieving remission of positional vertigo, improving dynamic postural stability and achieving self-management of the disorder.

Prior to the initial evaluation the referring professional should establish the diagnosis of vestibular hypofunction with definitive testing such as caloric testing or the rotary chair test. Appropriately trained referring professionals should perform these definitive tests and forward the results to the treating therapist for review during the initial evaluation. Clinical (bedside) tests that have also shown validity in identifying a vestibular disorder include the Dix-Hallpike Maneuver (for BPPV) and the Head Thrust Test (for vestibular hypofunction). Therapists with specialized training performing these tests should document the results in the medical record.

Treatment regimens as well as duration depends on the etiology of the vestibular disorder as follows:

- BPPV - usually is in remission within 2 visits; beyond 2 visits there should be justification in the medical record for continued treatment; beyond 4 visits with no remission there should be consideration of referral back to the Attending physician
- Partial or complete unilateral hypofunction (i.e. labyrinthitis, vestibular neuritis) - usually 1 visit/week for up to 6 weeks for optimal recovery in 90% of cases
- Bilateral vestibular hypofunction - usually requires 1 visit/week for up to 6 weeks but may require a longer treatment duration before maximum improvement

The above treatment regimens should only serve as a guide to individual management.

There are a few clinical conditions that routinely do not require vestibular rehabilitation unless combined with functional deficits. These include but are not limited to Meniere's disease and Perilymphatic fistula.

Compliance with a HEP is essential to the success of vestibular rehabilitation. A noncompliant patient should be considered for discharge. Documentation will be reviewed to determine appropriateness of continuing physical therapy intervention with patients who are noncompliant in their plan of treatment.

In order to insure that appropriate patients are selected for vestibular rehabilitation, certain ICD-9-CM codes within 386.XX should be used. The specific ICD-9-CM codes are listed in the appropriate section of the LCD. Gait abnormality alone would not justify the need for vestibular rehabilitation.

### **Additional Documentation Recommendations**

- Diagnostic testing results
- Home exercise program compliance
- Risk for falls validation (e.g. Dynamic Gait Index score)
- Adjunctive testing results (e.g. Activity specific balance confidence scale; Visual Analogue Scale; Tinetti, etc.)

### **SPECIFIC PROCEDURES AND MODALITIES**

#### *Peripheral Nerve Neurostimulators*

- **CPT 64550 - Application of surface (transcutaneous) neurostimulator:** This code is used for placement of electrodes for home

transcutaneous electrical nerve stimulator (TENS) units and instruction for use of home TENS units. Once the patient has been instructed on the use/placement of the home TENS unit, services are no longer covered. This service is generally not covered more than two (2) times in a twelve-month period.

### *Muscle and Range of Motion Testing*

- **CPTs 95831, 95832, 95833, 95834, 95851, and 95852:**
  - **Testing must be pertinent to the plan of care and the diagnosis**
  - **It is not reasonable or necessary for these services to be performed on a routine basis or to be routinely used for all patients**

### *Evaluations/Re-evaluations*

#### **CPTs 97001 and 97002:**

- **Evaluations are required prior to beginning therapy for determining the medical necessity of initiating rehabilitative or maintenance services. Patients must exhibit a significant change from normal functional ability to warrant an evaluation. Components of evaluations include the patient's history, relevant review of systems, pertinent physical assessment, and tests/measurements.**
- **Factors that influence the complexity of the evaluation process include the clinical findings, extent of loss of function, social considerations, and the patient's overall function and health status.**
- **The evaluation reflects the chronicity or severity of the current problem, the possibility of multi-site or multi-system involvement, the presence of preexisting systemic conditions or diseases, and the stability of the condition. If the patient presents with multi-system involvement and/or multiple site involvement, all areas/conditions should be assessed at the initial evaluation (i.e., cervical pain and knee pain; low back pain and rotator cuff; cervical pain and low back pain).**
- **Therapists also consider the level of the current impairments and the probability of prolonged impairment, functional limitation, and disability; the living environment; and the social supports (i.e., the potential for effecting an improvement in the patient's functional ability).**

- **Initial evaluations may be covered even when it is determined that a skilled level of service is not required if the patient's condition showed a need for the evaluation, even if the goals established by the plan of care are not realized. The patient is not eligible for further treatment if it has been determined that he/she is at maximum therapeutic potential and further therapy would not result in any significant improvement, such as may be the case with many chronic conditions.**
- **Initial evaluations from other therapy disciplines performed on the same beneficiary may also be covered, provided that the referral, evaluation and plan of treatment are not duplicative.**
- **Continuous evaluation of the patient's progress is a component of the ongoing physical therapy services. Therapy re-evaluations are covered if the documentation shows significant change in the patient's condition that supports the need to perform a formal re-evaluation of the patient's status. When a patient exhibits a demonstrable change in physical functional ability, a re-evaluation is covered to reestablish appropriate treatment goals and interventions.**
- **Routine screening, assessments and routine reassessments are not covered.**
- **A physical therapy visit for the evaluation of a non-covered service is also not covered. For example, pre-surgical evaluations for the purpose of teaching a HEP and giving assistive device instruction prior to a scheduled surgical procedure are not covered. This may include but is not limited to crutch walking, donning/doffing of post-surgical immobilizers and/or splints, and performing strengthening exercises.**

#### **Additional Documentation Recommendations**

**The written evaluation should demonstrate the patient's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The therapist should have an expectation that the patient will achieve the established goals.**

- **Initial evaluations should contain the following information:**
  - **Reason for referral and specific treatment requested**
  - **Diagnosis and functional condition/limitation being treated and onset date**
  - **Applicable medical history, medications, co-morbidities**

**(complicating or precautionary information)**

- **Primary subjective complaint**
  - **Mechanism of injury (if applicable)**
  - **Prior diagnostic imaging/testing**
  - **Prior level of function in the home and community in specific and measurable language**
  - **Prior therapy history**
  - **Baseline evaluation data - should be objective and measurable and include all applicable areas. The following list is not intended to be all-inclusive, but to be used as examples: cognition, vision/hearing, vascular signs, sensation/proprioception, edema, posture, active range of motion/passive range of motion, strength, pain, coordination, bed mobility, balance (sit and stand), transfers, ambulation (level and elevated/uneven surfaces), orthotic/prosthetic devices, wheelchair use, durable medical equipment (using or required), activity tolerance, wound description (including incision status), special tests (include the name and scores), and applicable architectural/safety considerations.**
  - **Assessment by therapist-reason for skilled care.**
  - **Problems listed**
- **The treatment plan is meant to serve as a guide to patient care. Revisions in the plan should be documented as the professional responds to changes in the patient's status. Revisions to the plan of treatment are expected when functional progress is not achieved within a reasonable period of time. The plan of treatment should include:**
    - **Specific treatment strategies (e.g., specific modalities to be used, specific type of activities and exercises)**
    - **Areas of the body to be treated**
    - **Frequency of treatment with the anticipated number of visits per week.**
    - **Duration**

- Patient instruction/home program
- Caregiver training
- Short term goals which are appropriate for the patient and the diagnosis and are stated in measurable terms with their expected date of accomplishment
- Long term goals which are appropriate for the patient and the diagnosis and are stated in measurable terms with their expected date of accomplishment
- Rehabilitation potential, which is a realistic evaluation of the patient's potential for rehabilitation/restoration using objective terminology.
- Signature and credentials of therapist performing the evaluation
- The components of the re-evaluation and the documentation requirements are the same as the initial evaluation, but are focused on assessing significant changes from the initial evaluation or progress toward treatment goals. Re-evaluations not addressing any of the functional impairments identified in the initial evaluation will be non-covered.

### *Modalities*

- CPTs 97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, G0281, G0283, and G0329
  - The use of modalities as stand-alone treatments are rarely therapeutic, and usually not required or indicated as the sole treatment approach to a patient's condition. The use of exercise and activities has proven to be an essential part of a therapeutic program. Therefore, a treatment plan should not consist solely of modalities, but include therapeutic procedures. Examples of exceptions are wound care or when a patient is unable to endure therapeutic procedures due to the acuteness of the condition. If a patient is unable to endure therapeutic procedures due to the acuteness of the condition, the number of visits for modalities should not exceed 2-4 visits.
  - Greater than two (2) modalities should not be used on each visit date.

- **A balance of supervised and constant attendance modalities should be used.**
- **Multiple heating modalities should not be used on the same day. Exceptions are rare and usually involve musculoskeletal pathology/injuries in which both superficial and deep structures are impaired. Documentation must support the medical necessity of multiple heating modalities as contributing to the patient's progress and restoration of function.**

### *Supervised Modalities*

**Application of the following modalities does not require direct (one-on-one) patient contact by the physical therapist.**

- **CPT code 97010 - Application of a modality to one or more areas; hot or cold packs**
  - **Hot or cold packs are used primarily in conjunction with therapeutic procedures to provide analgesia, relieve muscle spasm, and reduce inflammation and edema. Typically cold packs are used for acute, painful conditions, and hot packs for sub acute or chronic painful conditions.**
  - **Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications.**
  - **Hot or cold packs applied in the absence of associated procedures or modalities, or used alone to reduce discomfort are not considered reasonable and necessary and therefore, are not covered.**

### **Additional Documentation Recommendations**

**If these modalities are performed, they should be documented. The area/areas treated and the patient's response to treatment should be documented.**

- **CPT 97012 - Application of a modality to one or more areas; traction, mechanical**
  - **Traction is generally limited to the cervical or lumbar spine with the expectation of relieving pain in or originating from those areas.**
  - **Specific indications for the use of mechanical traction include cervical and/or lumbar radiculopathy and back disorders such as disc herniation, lumbago, and sciatica.**
  - **This modality is typically used in conjunction with therapeutic procedures, not as an isolated treatment.**
  - **Equipment and tables utilizing roller systems are not considered as true mechanical traction. Services using this type of equipment are non-covered.**
  - **Vertebral axial decompression (VAX-D) is performed for symptomatic relief of pain associated with lumbar disk problems. The treatment combines pelvic and/or cervical traction connected to a special table that permits the traction application. There is insufficient scientific data to support the benefits of this technique. Therefore, VAX-D is considered non-covered.**
  - **Supervised mechanical traction is generally not covered for greater than 3-4 visits to determine the efficacy of traction and to instruct the patient and/or caregiver in the use of a home traction unit, if traction is providing benefit. Documentation should support the medical necessity of continued treatment by the provider using this modality for greater than 4 visits.**

#### **Additional Documentation Recommendations**

- **Part of the body to which traction is applied**
- **Force of traction applied (pounds) and the angle of pull**
- **Amount of time the traction is applied**
- **Response of patient to treatment**
- **Response of patient and/or caregiver to education**
- **Functional progress at reassessment and discharge. If no**

**progress, the reason for lack of progress documented and /or alternative treatment strategy.**

- **CPT 97016 - Application of a modality to one or ore areas; vasopneumatic devices**
  - **Specific indications for the use of vasopneumatic devices include:**
    - **Reduction of edema after acute injury**
    - **Lymphedema of an extremity**
    - **Education on the use of a lymphedema pump**
  - **No more than 3 visits will generally be covered for educating the patient and/or caregiver in the use of lymphedema pump in the home.**
  - **Continued treatment by the provider using the vasopneumatic device after the educational visits is generally not medically necessary. If provider treatment is continued for additional visits, the documentation must support the medical necessity.**

#### **Additional Documentation Recommendations**

- **Area of the body being treated, location of edema**
- **Objective edema measurements with comparison to the uninvolved side**
- **Description of edema (e.g., pitting, non-pitting)**
- **Effect of edema on function**
- **Type of device used**
- **Response of patient to treatment**
- **Response of patient and/or caregiver to education**
- **CPT 97018 - Application of a modality to one or more areas; paraffin bath**
  - **Paraffin bath is primarily used for pain relief in chronic joint**

problems of the wrists, hands, or feet.

- **Specific indications for the use of paraffin bath include:**
  - **Contracture as a result of rheumatoid arthritis**
  - **Contracture as a result of scleroderma**
  - **Acute synovitis**
  - **Post-traumatic conditions**
  - **Hypertrophic scarring**
  - **Degenerative joint disease**
  - **Osteoarthritis**
  - **Post-surgical conditions or tendon repairs**
  - **Status post sprains or strain**
  
- **No greater than 2 visits will generally be covered to educate the patient and/or caregiver in home use and to evaluate effectiveness.**
  
- **Documentation must support the medical necessity of continued treatment and billing of this code by the provider for greater than 2 visits.**

#### **Additional Documentation Recommendations**

- **Area of body treated**
- **Response of patient to treatment**
- **Response of patient and/or caregiver to education**
  
- **CPT 97022 - Application of a modality to one or more areas; whirlpool**
  - **General whirlpool ordinarily does not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required may be considered medically necessary when the patient's condition is complicated by either circulatory or areas of desensitization, and the therapeutic goal is to increase circulation or decrease skin sensitivity.**

- **No greater than 6-8 visits should be billed. If greater than 8 visits are needed, the documentation must support the medical necessity of continued whirlpool treatment.**
- **Whirlpool therapy for the treatment of muscle spasms should not be used since there are other modalities that are more effective.**

#### **Additional Documentation Recommendations**

- **Area/areas being treated**
- **If used for weakness or range of motion, objective measurements of strength, range of motion, and/or functional deficits should be documented**
- **If used for circulatory or desensitization problems, the description of problem and effect on function should be documented**
- **Response of patient to treatment**
- **CPT 97024 - Application of a modality to one or more areas; diathermy**
  - **In accordance with CMS' NCD 150.5 for “Diathermy Treatment,” located at: [www.cms.hhs.gov](http://www.cms.hhs.gov), the use of diathermy is considered reasonable and necessary for the delivery of heat to deep tissues such as skeletal muscle and joints for the reduction of pain, joint stiffness, and muscle spasms.**
  - **Specific indications for the use of diathermy include:**
    - **Osteoarthritis, rheumatoid arthritis, or traumatic arthritis**
    - **A strain or sprain**
    - **Acute or chronic bursitis**
    - **Traumatic injury to muscle, ligament, or tendon resulting in functional loss**
    - **Joint dislocation or subluxation**

- **Treatment for a post surgical functional loss**
- **Adhesive capsulitis**
- **Joint contracture**
- **If no objective and/or subjective improvement noted after 6 treatments, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of this modality.**
- **This modality should be used in conjunction with therapeutic procedures, not as an isolated treatment.**
- **The efficacy of this modality should be met at most in 10-12 visits. Documentation must support the need of continued treatment with this modality for greater than 12 visits**
- **Diathermy is not considered reasonable and necessary for the treatment of asthma, bronchitis, or any other pulmonary condition.**

#### **Additional Documentation Recommendations**

- **Area/areas being treated**
- **Response of patient to treatment**
- **Objective clinical findings/measurements**
- **Subjective findings to include pain ratings, pain location, activities that increase or decrease pain, effect on function, etc.**
- **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative treatment strategy should be documented.**
- **CPT 97026 - Application of a modality to one or more areas, infrared**
  - **As of October 24, 2006, CMS has determined that there is sufficient evidence to conclude that the use of infrared devices is not reasonable and necessary for treatment of Medicare beneficiaries for diabetic and non-diabetic peripheral sensory neuropathy, wounds and ulcers, and similar related conditions, including symptoms such as pain arising from**

**these conditions. The use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is not covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of skin and/or subcutaneous tissues in Medicare beneficiaries. Refer to CMS' NCD 270.6, "Infrared Therapy Devices," for additional information.**

- **Superficial heat treatment of this type ordinarily does not require the skills of a qualified, licensed therapist and therefore is considered as a non-skilled service, which is not reimbursable.**
  - **This modality should be used in conjunction with therapeutic procedures, not as an isolated treatment. Infrared application in the absence of associated therapeutic procedures or modalities, or used alone to reduce discomfort, is considered not medically necessary, and therefore, is not covered.**
- **CPT 97028 - Application of a modality to one or more areas; ultraviolet**
    - **Treatment of this type is generally used for patients requiring the application of a drying heat. For example, this treatment would be considered reasonable and necessary for the treatment of severe psoriasis where there is limited range of motion.**
    - **Refer to CMS' NCD 250.1, "Treatment of Psoriasis," at: [www.cms.hhs.gov](http://www.cms.hhs.gov) for additional coverage information regarding using ultraviolet for the treatment of psoriasis.**

#### **Additional Documentation Recommendations**

- **Area/areas being treated**
- **Minimal erythema dosage should be documented**
- **Response of patient to treatment**

#### ***Constant Attendance Modalities***

**Application of the following modalities requires direct (one-on-one) patient contact by the physical therapist.**

## Electrical Stimulation for Non-Wound Care

- **CPT 97032 - Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes**
- **HCPCS G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care**
  - **TENS is used primarily for pain control. A patient can usually be taught to use a TENS unit for pain control in 1-2 visits. Documentation would need to support the medical necessity of services beyond 1-2 visits.**
  - **Refer to CMS' NCDs for coverage criteria and definition of electrical stimulation, Section 160, "Nervous System," at: [www.cms.hhs.gov](http://www.cms.hhs.gov)**
  - **Neuro-muscular stimulation is used for retraining weak muscles following surgery or injury. Typical treatment is no more than 12 visits when used as muscle re-training. Documentation must support the need for continued treatment beyond 12 visits for muscle re-training. In many instances the patient can be trained in the use of a home muscle stimulator for retraining weak muscles in 1-2 visits.**
  - **Muscle stimulation is a type of stimulation that is taken to the point of visible muscle contraction.**
  - **Interferential current/medium current (IFC) units use a frequency that allows the current to go deeper into the tissue. IFC is used to control swelling and pain. If no objective and/or subjective improvement in swelling and/or pain is noted after 6 visits, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of this modality. For swelling and pain control, the efficacy of this modality should be met in at most 10-12 visits. Documentation must support the need for continued treatment with this modality for greater than 12 visits.**
  - **Utilization of these modalities may be necessary during the initial phase of treatment, but there must be an improvement in function. These modalities should be utilized with appropriate therapeutic procedures to effect continued improvement. A limited number of visits without a**

**therapeutic procedure may be medically necessary for treatment of muscle spasm and swelling, but this should not exceed 2-4 visits.**

- **Specific indications for use include:**
  - **Documented dependent peripheral edema with an accompanying reduction in the ability to contract muscles**
  - **Documented reduction in the ability to contract muscles or in the strength of the muscle contraction**
  - **Documented condition that requires an educational program for self-stimulation of denervated muscles**
  - **Documented condition that requires muscle re-education involving a training program, i.e., functional electrical stimulation**
  - **Treatment for disuse atrophy using a specific type of neuromuscular electrical stimulator (NMES), which transmits an electrical impulse to the skin over selected muscle groups by way of electrodes. Coverage of NMES to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. Examples include casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). Typical treatment duration when electrical stimulation is used as muscle re-training is no more than 12 visits. Documentation must support the need for continued treatment beyond 12 visits for muscle re-training.**

#### **Electrical Stimulation and Electromagnetic Therapy for Wound Care**

- **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**
- **HCPCS 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**

- **Electrical stimulation and electromagnetic therapy for the treatment of chronic stage III or stage IV wounds will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Measurable signs of improved healing include a decrease in wound size either in surface area or volume, decrease in amount of exudates and decrease in amount of necrotic tissue. Standard wound care includes optimization of nutritional status; debridement by any means to remove devitalized tissue; maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; and necessary treatment to resolve any infection that may be present. Specific wound care based on type of wound includes frequent repositioning of a patient with pressure ulcers; off-loading of pressure and good glucose control for diabetic ulcers; establishment of adequate circulation for arterial ulcers; and the use of a compression system for patients with venous ulcers.**
- **Electromagnetic therapy (e.g. Diapulse<sup>®</sup> Wound Treatment System<sup>™</sup>, PROVANT<sup>®</sup> Wound Closure System) is a form of treatment that involves the production of induced current from the application of electromagnetic fields rather than the application of electrical current directly from electrodes on the skin surface. Energy is delivered by non-contacting means (e.g. coils) rather than by leads and surface electrodes.**
- **For additional information on coverage criteria for electrical stimulation for the treatment of wounds, refer to CMS' NCD 270.1, "Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds, located at: [www.cms.hhs.gov](http://www.cms.hhs.gov)**

#### **Additional Documentation Recommendations**

- **Type of electrical stimulation used.**
- **Area/areas being treated.**
- **If used for wounds, the description of wound location, size,**

**drainage, odor, and tissue appearance; parameters used for modality; and precautionary information should be documented.**

- **If used for muscle weakness, objective rating of strength and functional deficits should be documented.**
  - **If used for swelling/edema, location of edema, description of edema, effect of edema on function should be documented.**
  - **If used for pain, pain rating, location of pain, effect of pain on function should be documented.**
  - **Response of patient to treatment and/or education.**
  - **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative treatment strategy should be documented.**
- **CPT 97033 - Application of a modality to one or more areas; iontophoresis, each 15 minutes**
    - **Iontophoresis is a process in which electrically charged molecules or atoms are driven into tissue with an electrical field. Voltage provides the driving force.**
    - **The application of iontophoresis is considered medically necessary for the topical delivery of medications into a specific area of the body.**
    - **If no objective and/or subjective improvement are noted after 8 treatments, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of this modality. The efficacy of this modality should be met in at most 10-12 visits. Documentation must support the need for continued treatment with this modality for greater than 12 visits.**
    - **This modality should be used in conjunction with therapeutic procedures.**
    - **Coverage for iontophoresis when delivered by means of a '24 hour patch' is only for the time spent for the initial application and is generally covered for 1-2 visits to establish efficacy. Subsequent visits for reapplication generally do not require the skills of a licensed therapist and therefore are noncovered.**

## **Additional Documentation Recommendations**

- **Area/areas being treated**
- **Medication and dosage information**
- **Response of patient to treatment**
- **Objective clinical findings/measurements of strength and range of motion and functional deficits/limitations**
- **Subjective findings related to pain location, pain rating, effect of pain on function**
- **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative treatment strategy should be documented.**
- **CPT 97034 - Application of a modality to one or more areas; contrast baths, each 15 minutes**
  - **Contrast baths are a form of therapeutic heat and cold applied to distal extremities in an alternating pattern. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold. The use of contrast baths is considered medically necessary to desensitize patients to pain.**
  - **The use of contrast baths may be considered medically necessary for the following:**
    - **Documented rheumatoid arthritis or other inflammatory arthritis**
    - **Documented reflex sympathetic dystrophy**
    - **Documented sprain or strain resulting from an acute injury**
  - **Hot and cold baths ordinarily do not require the skills of a licensed therapist. However, the skills, knowledge and judgment of a licensed therapist might be required in the giving of such treatments in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fracture or other**

**complication. Documentation must indicate the presence of these complicating factors for reimbursement of this service. If there were no complicating factors, which would necessitate the skills of a licensed therapist to perform this modality, the modality would be non-covered. However, it could be considered reasonable and necessary for 1-2 visits for instruction to the patient and/or caregivers in the performance of this modality and to assess the patient's response to the modality.**

- **This modality should be used in conjunction with therapeutic procedures, not as an isolated treatment.**

#### **Additional Documentation Recommendations**

- **Area/areas being treated.**
- **Subjective findings to include pain ratings, pain location, effect on function.**
- **Patient response to treatment and/or education.**
- **CPT 97035 - Application of a modality to one or more areas; ultrasound, each 15 minutes**
  - **Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 MHz. In the human body ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone may receive as much as 30% greater dosage of ultrasound than tissue not adjacent to bone. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where tissue may receive a more intense irradiation, ultrasound is an ideal modality for increasing mobility in those tissues with restricted range of motion.**
  - **The use of ultrasound is considered reasonable and necessary for patients requiring deep heat to a specific area for reduction of pain, spasm, and joint stiffness, and for increased flexibility of muscle, tendons, and ligaments.**
  - **Specific indications for the use of ultrasound application**

**include but are not limited to:**

- **Documented tightened structures limiting joint motion that require an increase in extensibility**
  - **Documented symptomatic soft tissue calcification**
  - **Documented neuromas**
- 
- **Non-thermal ultrasound for wound healing may be indicated for non-necrotic wound(s) only after documented standard wound care has been used for a minimum of 30 days with no measurable signs of healing.**
  - **Ultrasound application is not considered reasonable and necessary for the treatment of asthma, bronchitis, or any other pulmonary condition.**
  - **This modality should be used in conjunction with therapeutic procedures, not as an isolated treatment.**
  - **If no objective and/or subjective improvement noted after 6 treatments, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of this modality.**
  - **The efficacy of this modality should be met in at most 12 visits. Documentation must support the need for continued treatment with this modality for greater than 12 visits.**

#### **Additional Documentation Recommendations**

- **Area/Areas being treated**
- **Frequency and intensity of modality and time applied**
- **Response of patient to treatment**
- **Objective clinical findings/measurements of strength, range of motion, and functional deficits/limitations**
- **Subjective findings to include pain ratings, pain location, effect on function**
- **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative**

treatment strategy should be documented.

### ***THERAPEUTIC PROCEDURES***

- **CPT 97110, 97112, 97113, 97116, 97124, 97140, 97530, 97535, 97542**
  - **Therapeutic procedures are procedures that attempt to reduce impairments and restore function through the application of clinical skills and/or services.**
  - **Use of these procedures requires the therapist to have direct (one-on-one) patient contact. Supervision of a previously taught exercise or exercise program, patients performing an exercise independently without direct contact by the provider, use of different exercise equipment without requiring the intervention/skills of the therapist are not covered.**
  - **Use of these procedures is expected to result in improvement of the limitations/deficits in a reasonable and generally predictable period of time.**
  - **The expected goals documented in the treatment plan, affected by the use of each of these procedures, will help define whether these procedures are reasonable and necessary. Therefore, since any one or a combination of more than one of these procedures may be used in a treatment plan, documentation must support the use of these procedures as they relate to a specific therapeutic goal.**
  - **Services provided concurrently by a physical therapist and an occupational therapist may be covered if separate and distinct goals are documented in the treatment plan and there is no duplication of the specific treatment / procedures being provided.**
- **CPT 97110 - Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility**
  - **Therapeutic exercises are performed with the patient actively, active-assisted, or passively participating. Passive only exercise programs should not be used more than 2-4 visits. In certain specialized situations, (e.g. recent rotator cuff repair), passive range of motion (ROM) may be required beyond 2-4 visits. Therapeutic exercises are used for the purpose of restoring strength, range of motion and flexibility. For**

**example, a gym ball exercise used for the purpose of increasing the patient's strength should be considered as therapeutic exercise.**

- **The exercise component for manual lymphatic drainage is covered under CPT 97110 and generally requires no more than 2-4 visits.**
- **Therapeutic exercises may be reasonable and necessary for a documented loss or restriction of joint motion, strength, functional capacity or mobility, which has resulted from a specific disease or injury.**
- **Therapeutic exercise may be supported as reasonable and necessary if at least one of the following conditions is present and described in the documentation:**
  - **The patient having weakness, contracture, stiffness secondary to spasm, spasticity, decreased range of motion, gait problems, balance and/or coordination deficits, abnormal posture, and muscle imbalance.**
  - **The patient needing to improve mobility, stretching, strengthening, coordination, control of extremities, dexterity, range of motion, or endurance as part of activities of daily living training, or re-education.**
- **Documentation for therapeutic exercise must show objective loss of joint motion, strength, and mobility, (e.g., degrees of motion, strength grades, or levels of assistance).**
- **Repetitive exercises to promote overall fitness, flexibility, endurance enhancing, aerobic conditioning, weight reduction, and maintenance exercises to maintain range of motion and/or strength are non-covered.**
- **Passive exercises not related to restoring specific loss of function are non-covered.**
- **This code is generally not covered for greater than 12-18 visits within a 4-6 week period. Documentation must support the need for continued treatment beyond this frequency and duration.**

#### **Additional Documentation Recommendations**

- **Objective measurements of strength, range of motion (with comparison to the uninvolved side), and mobility**
- **Specific exercises performed, purpose of exercises as related to function, instruction given, and/or assistance needed**
- **Documentation to support that the skills and expertise of the physical therapist were required.**
- **Functional limitations/deficits as result of the strength, range of motion, and/or flexibility deficits**
- **Response of patient to treatment**
- **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative treatment strategy should be documented.**
- **CPT 97112 - Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities**
  - **Therapeutic procedures include the following activities: proprioceptive neuromuscular facilitation (PNF), Feldenkreis, Bobath, BAP's boards, and desensitization techniques.**
  - **Therapeutic procedures may be reasonable and necessary for impairments which affect the body's neuromuscular system such as:**
    - **Documented loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers**
    - **Documented nerve palsy, such as peroneal nerve injury causing foot drop**
    - **Documented muscular weakness or flaccidity as result of a cerebral dysfunction, a nerve injury or disease or having had a spinal cord disease or trauma**
    - **Documented poor static or dynamic sitting/standing balance**
    - **Documented loss of gross and fine motor coordination**
    - **Documented hypo/hypertonicity**

- **Documentation for neuromuscular reeducation must show impairments which affect the neuromuscular system as listed above, and must contain objective measurements/ratings of loss of motion, strength, balance, coordination, and/or mobility (e.g., degrees of motion, strength grades, assist for balance and mobility, specific tests for balance and coordination).**
- **This code is generally not covered for greater than 12-18 visits within a 4-6 week period. Documentation must support the need for continued treatment beyond this frequency and duration.**

#### **Additional Documentation Recommendations**

- **Objective measurements of strength and range of motion (with comparison to the uninvolved side) and mobility, balance, and coordination deficits**
- **Specific exercises performed, purpose of exercises as related to function, instruction given, and/or assistance needed**
- **Documentation to support that the skills and expertise of the physical therapist were required**
- **Functional limitations/deficits as result of the neuromuscular impairment**
- **Response of patient to treatment**
- **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative treatment strategy should be documented.**
- **CPT 97113 - Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises**
  - **This procedure may be reasonable and necessary for the loss or restriction of joint motion, strength, mobility, or function due to pain, injury, or illness by using the buoyancy and resistance properties of water. This activity must be provided on a one-to-one basis.**
  - **Aquatic therapy with therapeutic exercise may be considered reasonable and necessary for a patient having the inability to**

**tolerate land based exercises for rehabilitation. Aquatic therapy exercises may be used to facilitate progression to land based therapy or to increased function. Documentation must support this.**

- **Repetitive exercises in the water environment to promote overall fitness, flexibility, endurance enhancing, aerobic conditioning, weight reduction, or for maintenance purposes are non-covered.**
- **This code is generally not covered for greater than 6-8 visits. If continued aquatic exercise is needed, the patient should be instructed in a HEP during these visits. Documentation must support the need for continued treatment beyond 8 visits.**

#### **Additional Documentation Recommendations**

- **Objective measurements of loss of strength and range of motion (with comparison to the uninvolved side) and mobility**
- **Specific exercises performed, purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises**
- **Documentation to support that the skills and expertise of the physical therapist were required.**
- **Functional limitations/deficits as result of the strength, range of motion, and/or flexibility deficits**
- **Response of patient to treatment and/or education**
- **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative treatment strategy should be documented.**
- **CPT 97116 - Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)**
  - **This procedure may be reasonable and necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.**
  - **Specific indications for gait training include:**
    - **The patient having suffered a cerebral vascular accident resulting in impairment in the ability to**

**ambulate, now stabilized and ready to begin rehabilitation**

- **The patient having recently suffered a musculoskeletal trauma, requiring ambulation re-education**
  - **The patient having a chronic, progressively debilitating condition for which safe ambulation has recently become a concern**
  - **The patient having had an injury or condition that requires instruction in the use of a walker, crutches, or cane**
  - **The patient having been fitted with a brace/lower limb prosthesis and requires instruction in ambulation**
- **Gait training is not considered reasonable and necessary when the patient's walking ability is not expected to improve.**
  - **Repetitive walking/strengthening exercises for feeble or unstable patients or to increase endurance or gait distance does not require the skills of the therapist and is considered not reasonable and necessary and is non-covered.**
  - **This code is generally not covered for greater than 12-18 visits within a 4-6 week period. Documentation must support the need for continued treatment beyond this frequency and duration.**

#### **Additional Documentation Recommendations**

- **Objective measurements of balance and gait distance, assistive device used, amount of assistance required, gait deviations and limitations being addressed, use of orthotic or prosthesis, need for and description of verbal cueing**
- **Documentation to support that the skills and expertise of the physical therapist were required**
- **Presence of complicating factors (pain, balance deficits, gait deficits, stairs, architectural or safety concerns)**
- **Response of patient to treatment/education**
- **Functional progress at reassessment and discharge. If no progress, the reason for lack of progress and/or alternative**

**treatment strategy should be documented.**

- **CPT 97124 - Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)**
  - **Massage is the application of systemic manipulation to the soft tissues of the body for therapeutic purposes. Although various assistive devices and electrical equipment are available for the purpose of delivering massage, use of the hands is considered the most effective method of application, because palpation can be used as an assessment as well as a treatment tool. Therefore, massage performed with devices or electrical equipment is non-covered.**
  - **Therapeutic massage may be considered reasonable and necessary as adjunctive treatment to another therapeutic procedure on the same day, and is designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm.**
  - **The medical necessity of therapeutic massage may be supported if the documentation shows at least one of the following conditions:**
    - **The patient having paralyzed musculature contributing to impaired circulation**
    - **The patient having sensitivity of tissues to pressure**
    - **The patient having tight muscles resulting in shortening and/or spasticity of affected muscles**
    - **The patient having abnormal adherence of tissue to surrounding tissue**
    - **The patient requiring relaxation in preparation for neuromuscular re-education or therapeutic exercise**
    - **The patient having contractures and decreased range of motion**
  - **In most cases, other caregivers can carry out percussion, for the use in postural drainage, safely and effectively. If the attending physician determines that for the safe and effective administration of these procedures, the professional skills of a**

**physical therapist are required, coverage may be allowed. Documentation should support the above requirements.**

- **This procedure is not covered as an isolated treatment.**
- **This procedure is generally not covered for greater than 6-8 visits with instruction to patient and caregiver for continued treatment. Documentation must support the need for continued treatment beyond 8 visits.**

#### **Additional Documentation Recommendations**

- **Area/areas being treated**
- **Technique used**
- **Response of patient to treatment/education**
- **CPT 97140 - Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes**
  - **Manual traction may be considered reasonable and necessary for cervical radiculopathy**
  - **Joint mobilization (peripheral or spinal) may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.**
  - **Myofascial release/soft tissue mobilization, one or more regions, may be reasonable and necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. This procedure may be reasonable and necessary as an adjunct to other therapeutic procedures**
  - **Manipulation may be reasonable and necessary for treatment of painful spasm or restricted motion of soft tissues. This procedure may be reasonable and necessary as an adjunct to other therapeutic procedures.**
  - **Manual lymphatic drainage/complete decongestive therapy (MLD) may be reasonable and necessary for documented**

**lymphedema. The physical therapist should be trained in MLD. The goal of treatment is to reduce lymphedema of an extremity by routing the fluid to functional pathways, preventing backflow as the new routes become established, and to use the most appropriate methods to maintain the reduction of the extremity after therapy is complete. This therapy involves intensive treatment to reduce the size of the extremity by a combination of manual decongestive therapy and serial compression bandaging, followed by an exercise program. During these sessions, education should be provided to the patient and/or caregiver on the correct application of the compression bandage. In moderate-severe lymphedema, daily visits may be required for the initial visits.**

- **After the completion of the therapy the patient and/or caregiver could perform these activities without supervision.**
- **This code is generally not covered for greater than 12-18 visits within a 4-6 week period. Documentation must support the need for continued treatment beyond this frequency and duration. When the patient and/or caregiver have been instructed in the performance of specific techniques, the performance of these techniques should not be continued by the physical therapist.**

#### **Additional Documentation Recommendations**

- **Area/areas being treated**
- **Soft tissue/mobilization technique used**
- **Objective and subjective measurements of areas treated, including measurement differences before and after treatment, or comparing the affected to the unaffected limb**
- **Functional limitations/deficits, effect of treatment on function**
- **Response of patient to treatment/education**
- **CPT 97530 - Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes**
  - **Therapeutic activities are considered reasonable and necessary for patients needing a broad range of rehabilitative techniques that involves movement. Movement activities can**

be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, transfers, and overhead activities) to restore functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the skills of the physical therapist to design the activities to address a specific functional need of the patient and to instruct the patient in performance of these activities. These dynamic activities must be part of an active treatment plan and be directed at a specific outcome.

- In order for therapeutic activities to be covered, the following requirements must be met:
  - The patient has a documented condition for which therapeutic activities can reasonably be expected to restore or improve functioning
  - There is a clear correlation between the type of exercise performed and the patient's underlying medical condition for which the therapeutic activities were prescribed
  - The patient's condition is such that he/she is unable to perform the therapeutic activities without the skilled intervention of the physical therapist
- This code is generally not covered for greater than 10-12 visits. Documentation must support the need for continued treatment beyond 12 visits.

#### **Additional Documentation Recommendations**

- **Objective measurements of balance, strength, coordination, mobility, etc.**
- **Specific activities performed, amount of assistance required.**
- **Documentation to support that the skills and expertise of the therapist were needed**
- **Functional limitations addressed**
- **Functional progress at reassessment and discharge. If no**

**progress, the reason for lack of progress and/or alternative treatment strategy should be documented..**

- **CPT 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 by provider, each 15 minutes**
  - **This procedure is reasonable and necessary only when it requires the skills of a therapist, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific outcome.**
  - **The patient must have a condition for which training in activities of daily living is reasonable and necessary, and such training must be reasonably expected to restore or improve the functioning of the patient. Documentation must relate the training to expected functional goals that are attainable by the patient.**
  - **The patient and/or caregiver must have the capacity to learn from instructions.**
  - **Services provided concurrently by physical therapists and occupational therapists may be covered if separate and distinct goals are documented in the treatment plans and there is no duplication of services.**
  - **This code should be seldom used by physical therapy. If this code is used by physical therapy, significant and specific documentation should support the use of the code.**
  - **The physical therapist is expected to explain the benefits of the instruction in order to determine that the patient is motivated and desires to improve their level of function. Providing treatment to a patient that has been able to verbalize that they do not want to improve their functional level is not reasonable and necessary.**

#### **Additional Documentation Recommendations**

- **The specific ADL addressed and/or compensatory training provided, specific safety procedures addressed, specific adaptive equipment utilized and instruction given should be documented and the functional limitation/deficit which is**

expected to be effected

- Documentation should support that the services rendered required the skills and expertise to the therapist
- **CPT 97542 - Wheelchair management (eg,assessment, fitting, training), each 15 minutes**
  - This procedure is considered reasonable and necessary only when it requires the professional skills of a therapist, and is designed to address specific needs of the patient
  - The patient must have the capacity to learn from instructions
  - Instruction in the routine operation of an electric wheelchair is generally non-covered
  - Wheelchair evaluations, when medically necessary, are a part of a complete therapy evaluation
  - Visits made for restraint reduction are generally non-covered
  - A total of 2-3 visits should be sufficient after an ordered wheelchair has arrived. Coverage beyond this utilization must have documentation to support the need for an unusual frequency or duration of treatment sessions. Visits prior to the wheelchair arrival are generally not covered
  - CMS' NCD 280.3, CMS' NCD 280.3, "Mobility Assistive Equipment" (MAE), at: [www.cms.hhs.gov](http://www.cms.hhs.gov) outlines the necessary components of documentation that need to be met for coverage

#### **Additional Documentation Recommendations**

- Documentation should relate the training to expected functional goals that are attainable by the patient and /or caregiver
- The specific wheelchair management activity should be clearly documented and addressing a specific measurable goal related to functional activity

#### ***Tests and Measurements***

- **CPT 97750 - Physical Performance Test or Measurement**

- **This testing may be reasonable and necessary for patients with neurological or musculoskeletal conditions. These tests and measurements are over and above the usual evaluation services performed. Examples of physical performance tests or measurements include isokinetic testing or Functional Capacity Evaluation (FCE).**
- **There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. Usually this report includes torque curves and other graphic reports with interpretation.**
- **It is not reasonable and necessary for the test to be performed and billed on a routine basis (e.g., monthly or instead of billing a reevaluation) or to be routinely performed on all patients treated.**
- **Initial isokinetic testing may be allowed for a comparison of the involved and uninvolved extremity.**
- **The Functional Capacity Evaluation (FCE) is primarily intended for disability determination or workman's compensation status; therefore, would not be a routine service for Medicare beneficiaries.**

#### **Additional Documentation Recommendations**

- **Problem requiring the test and the specific test performed**
- **Separate measurement report, including any graphic reports**
- **Application to functional activity**
- **How the test impacts the plan of care**
- **CPT 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 by provider, with written report, each 15 minutes**
  - **Provider performs an assessment for the suitability and benefits of acquiring any assistive technology device or equipment that will help restore, augment, or compensate for existing functional ability in the patient (i.e. provision of large amounts of rehabilitative engineering).**

- Coverage is specifically for assessment of mobility and seating systems that require high level adaptations, not for routine seating and mobility systems (e.g. manual/power wheelchair evaluations).
- Utilization of this service should be infrequent.

### ***Orthotic Management and Prosthetic Management***

- **CPT 97760 - Orthotic(s) Management and Training (including assessment and fitting when not otherwise reported), upper extremity(s) and/or trunk, each 15 minutes**

#### **General Orthotics Guidelines**

- Under Medicare there are provisions for coverage and reimbursement for orthotics under the HCPCS Level II Coding System. Both prefabricated (commercial, off-the-shelf, non-individualized, etc.) and custom orthotics may be covered
- Coverage of orthotics includes evaluating the patient, taking measurements, making modifications, follow-up visits, and making adjustments as appropriate
- Training (as appropriate) in the use of orthotic devices is used to enhance the performance of tasks or movements, support weak or ineffective joints or muscles, reduce/correct joint limitations/deformities, and/or protect body parts from injury. The orthotic is often used in conjunction with therapeutic exercise, functional training, and other interventions and should be selected in the context of the patient's need.
- The physical therapist targets the problems in performance of movements or tasks and selects the most appropriate device or equipment, then fits the device, and trains the patient and/or caregivers in its use and application. The goal is for the patient to function at a higher level by decreasing functional limitations or the risk of further functional limitations.
- The complexity of the patient's need is to be documented to show the medical necessity of skilled physical therapy to assess, fit, instruct, and adjust.

- **Ongoing visits for increasing wearing time are generally not reasonable and necessary when patient problems have not been observed.**
- **Geri-chair, wheelchair, and bed bound positioning are covered based on medical necessity as well as the type orthotic (customized vs. prefabricated) used.**

#### **Additional Documentation Recommendations**

- **Specific type of orthotic used and area applied**
- **Any complicating factors**
- **Response of patient to treatment and education**

#### **Customized Orthotics Guidelines**

- **'Custom fabricated' means the item is individually made for a patient using: a) a plaster model of the patient, b) computer generated model, or c) detached measurements of the patient used to create a carved foam custom fabricated support. Documentation should include parameters used in custom fabrication.**
  - **Repetitive range of motion prior to placing a customized orthotic/positioner to maintain the range of motion is not reasonable and necessary when the therapeutic intent is to primarily maintain range of motion within a chronic condition.**
  - **Additional visits made to continue to assess for the customized orthotic need to be clarified to establish medical necessity. The customized orthotic should be available in a timely fashion. The customized orthotic/positioning program is to be set up and then taught to the patient or caregiver for follow through. Monitoring by the physical therapist is non-covered.**
  - **Upon issuing the custom fabricated orthotic, staff/caregiver instruction should be done simultaneously. Ongoing visits by the physical therapist to apply the device would be considered monitoring. Once the initial fit is established, any further visits should be used for specific documented problems and modifications that require skilled physical therapy services. It is reasonable and necessary to require 1-2 visits to educate the patient or caregiver. Clinical documentation must support the**

**need for additional visits. More than 2 visits to evaluate, and teach caregivers is not considered reasonable and necessary without significant supportive documentation.**

- **CPT 97761 - Prosthetic training, upper and/or lower extremity(s), each 15 minutes**

**This procedure may be considered reasonable and necessary if there is an indication for education on the prosthesis, the prosthesis is in the home, and the functional use of the prosthesis is documented.**

#### **Additional Documentation Recommendations**

- **Type of prosthesis, extremity involved.**
- **Specific training provided; amount of assistance needed**
- **Any complicating factors and specific description of these (with objective measurements), such as pain, joint restrictions/contractures, strength deficits, etc.**
- **CPT 97762 - Checkout for orthotic/prosthetic use, established patient, each 15 minutes**
  - **These assessments are reasonable and necessary when there is a modification of the customized (not prefabricated) orthotic/prosthetic device.**
  - **These assessments may be reasonable and necessary when patients experience a loss or change of function directly related to the device (e.g., pain, decreased swelling, skin breakdown, and falls).**
  - **These assessments may not be considered reasonable and necessary when a device is reissued or replaced after normal wear and no modifications are needed.**
  - **A total of 1-2 visits should be sufficient. Documentation must support the need for continued treatment beyond 2 visits.**

#### **Additional Documentation Recommendations**

- **Reason for assessment.**
- **Specific device, modifications made, instruction given.**

## Coverage Topic [back to top](#)

Home Health Care

Physical, Occupational, and Speech Therapy

## Coding Information

### Bill Type Codes: [back to top](#)

**Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.**

32x HHA-inpatient or home health visits (Part B only)

33x HHA-outpatient (HHA-A also)

### Revenue Codes: [back to top](#)

**Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.**

042X Physical therapy-general classification

### CPT/HCPCS Codes [back to top](#)

As of July 1999, physical therapists must report time spent with the patient in 15-minute increments. The following code should be used by physical therapy:

G0151 HHCP-serv of pt,ea 15 min

Other CPT/HCPC codes found in this policy are for informational and descriptive use only.

64550	Apply neurostimulator
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
97001	Pt evaluation
97002	Pt re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97530	Therapeutic activities
97535	Self care mngment training

97542	Wheelchair mngment training
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

**ICD-9 Codes that Support Medical Necessity** [back to top](#)

138	LATE EFFECTS OF ACUTE POLIOMYELITIS
333.83	SPASMODIC TORTICOLLIS
337.22	REFLEX SYMPATHETIC DYSTROPHY OF THE LOWER LIMB
<a href="#">342.00 -</a> <a href="#">342.92</a>	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
<a href="#">344.00 -</a> <a href="#">344.9</a>	QUADRIPLEGIA UNSPECIFIED - PARALYSIS UNSPECIFIED
<a href="#">353.0 -</a> <a href="#">353.8</a>	BRACHIAL PLEXUS LESIONS - OTHER NERVE ROOT AND PLEXUS DISORDERS
<a href="#">354.0 -</a> <a href="#">354.8</a>	CARPAL TUNNEL SYNDROME - OTHER MONONEURITIS OF UPPER LIMB
<a href="#">355.0 -</a> <a href="#">355.8</a>	LESION OF SCIATIC NERVE - MONONEURITIS OF LOWER LIMB UNSPECIFIED
356.1	PERONEAL MUSCULAR ATROPHY
368.41	SCOTOMA INVOLVING CENTRAL AREA
368.45	GENERALIZED VISUAL FIELD CONTRACTION OR CONSTRICTION

- 368.46 HOMONYMOUS BILATERAL FIELD DEFECTS
- 368.47 HETERONYMOUS BILATERAL FIELD DEFECTS
- 369.01 BETTER EYE: TOTAL VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
- 369.03 BETTER EYE: NEAR-TOTAL VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
- 369.04 BETTER EYE: NEAR-TOTAL VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
- 369.06 BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
- 369.07 BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
- 369.08 BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
- 369.12 BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
- 369.13 BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
- 369.14 BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
- 369.16 BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
- 369.17 BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
- 369.18 BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
- 369.22 BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: SEVERE VISION IMPAIRMENT
- 369.24 BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: SEVERE VISION IMPAIRMENT
- 369.25 BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: MODERATE VISION IMPAIRMENT
- 386.11 BENIGN PAROXYSMAL POSITIONAL VERTIGO
- 386.12 VESTIBULAR NEURONITIS

[386.51](#) - HYPERACTIVE LABYRINTH UNILATERAL - LOSS OF  
[386.56](#) LABYRINTHINE REACTIVITY BILATERAL

413.9 OTHER AND UNSPECIFIED ANGINA PECTORIS

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[438.53](#) PARALYTIC SYNDROME BILATERAL

438.81 APRAXIA CEREBROVASCULAR DISEASE

438.82 DYSPHAGIA CEREBROVASCULAR DISEASE

438.83 FACIAL WEAKNESS

438.84 ATAXIA

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[454.2](#) - VARICOSE VEINS OF LOWER EXTREMITIES WITH  
ULCER AND INFLAMMATION

457.0 POSTMASTECTOMY LYMPHEDEMA SYNDROME

457.1 OTHER LYMPHEDEMA

459.31 CHRONIC VENOUS HYPERTENSION WITH ULCER

459.33 CHRONIC VENOUS HYPERTENSION WITH ULCER AND  
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514 PULMONARY CONGESTION AND HYPOSTASIS

625.6 STRESS INCONTINENCE FEMALE

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[682.0](#) - CELLULITIS AND ABSCESS OF FACE - CELLULITIS AND  
[682.7](#) ABSCESS OF FOOT EXCEPT TOES

683 ACUTE LYMPHADENITIS

[707.00](#) - DECUBITUS ULCER, UNSPECIFIED SITE - CHRONIC  
[707.9](#) ULCER OF UNSPECIFIED SITE

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[718.49](#) CONTRACTURE OF JOINT OF MULTIPLE SITES

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[718.59](#) ANKYLOSIS OF JOINT OF MULTIPLE SITES

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[719.09](#) JOINT OF MULTIPLE SITES

[719.40](#) - PAIN IN JOINT SITE UNSPECIFIED - PAIN IN JOINT  
[719.47](#) INVOLVING ANKLE AND FOOT

719.49 PAIN IN JOINT INVOLVING MULTIPLE SITES

[719.51](#) - STIFFNESS OF JOINT NOT ELSEWHERE CLASSIFIED  
[719.59](#) INVOLVING SHOULDER REGION - STIFFNESS OF JOINT  
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719.7 DIFFICULTY IN WALKING

720.2 SACROILIITIS NOT ELSEWHERE CLASSIFIED

722.0 DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC  
WITHOUT MYELOPATHY

722.10 DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC  
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722.11 DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC  
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723.3 CERVICOBRACHIAL SYNDROME (DIFFUSE)

723.4 BRACHIAL NEURITIS OR RADICULITIS NOS

723.5 TORTICOLLIS UNSPECIFIED

724.1 PAIN IN THORACIC SPINE

724.2 LUMBAGO

724.3 SCIATICA

724.4 THORACIC OR LUMBOSACRAL NEURITIS OR  
RADICULITIS UNSPECIFIED

724.5 BACKACHE UNSPECIFIED

724.6 DISORDERS OF SACRUM

724.8 OTHER SYMPTOMS REFERABLE TO BACK

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728.4 LAXITY OF LIGAMENT

728.5 HYPERMOBILITY SYNDROME

728.6 CONTRACTURE OF PALMAR FASCIA

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[728.81](#) - INTERSTITIAL MYOSITIS - SPASM OF MUSCLE  
[728.85](#)

728.87 MUSCLE WEAKNESS (GENERALIZED)

728.89 OTHER DISORDERS OF MUSCLE LIGAMENT AND FASCIA

728.9 UNSPECIFIED DISORDER OF MUSCLE LIGAMENT AND FASCIA

729.5 PAIN IN LIMB

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729.9 OTHER AND UNSPECIFIED DISORDERS OF SOFT TISSUE

736.05 WRIST DROP (ACQUIRED)

736.1 Mallet Finger

736.21 Boutonniere Deformity

736.79 OTHER ACQUIRED DEFORMITIES OF ANKLE AND FOOT

736.81 UNEQUAL LEG LENGTH (ACQUIRED)

754.1 CONGENITAL MUSCULOSKELETAL DEFORMITIES OF STERNOCLEIDOMASTOID MUSCLE

781.0 ABNORMAL INVOLUNTARY MOVEMENTS

781.2 ABNORMALITY OF GAIT

781.3 LACK OF COORDINATION

781.4 TRANSIENT PARALYSIS OF LIMB

781.8 NEUROLOGICAL NEGLECT SYNDROME

781.92 ABNORMAL POSTURE

781.94 FACIAL WEAKNESS

781.99 OTHER SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYSTEMS

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785.4 GANGRENE

786.4 ABNORMAL SPUTUM

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[831.09](#) CLOSED DISLOCATION OF OTHER SITE OF SHOULDER

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[833.01](#) - CLOSED DISLOCATION OF RADIOULNAR (JOINT) DISTAL  
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[834.01](#) - CLOSED DISLOCATION OF METACARPOPHALANGEAL  
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[841.0](#) - RADIAL COLLATERAL LIGAMENT SPRAIN - SPRAIN OF  
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[842.01](#) - SPRAIN OF CARPAL (JOINT) OF WRIST - OTHER WRIST  
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[842.19](#) OTHER HAND SPRAIN

[843.0](#) - ILIOFEMORAL (LIGAMENT) SPRAIN - SPRAIN OF OTHER  
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[844.0](#) - SPRAIN OF LATERAL COLLATERAL LIGAMENT OF KNEE -  
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[845.01](#) - DELTOID (LIGAMENT) ANKLE SPRAIN - OTHER ANKLE  
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[847.0 - 847.4](#) NECK SPRAIN - SPRAIN OF COCCYX

848.41 STERNOCLAVICULAR (JOINT) (LIGAMENT) SPRAIN

848.42 CHONDROSTERNAL (JOINT) SPRAIN

848.5 PELVIC SPRAIN

[880.00 - 880.09](#) OPEN WOUND OF SHOULDER REGION WITHOUT COMPLICATION - OPEN WOUND OF MULTIPLE SITES OF SHOULDER AND UPPER ARM WITHOUT COMPLICATION

[880.10 - 880.19](#) OPEN WOUND OF SHOULDER REGION COMPLICATED - OPEN WOUND OF MULTIPLE SITES OF SHOULDER AND UPPER ARM COMPLICATED

[880.20 - 880.29](#) OPEN WOUND OF SHOULDER REGION WITH TENDON INVOLVEMENT - OPEN WOUND OF MULTIPLE SITES OF SHOULDER AND UPPER ARM WITH TENDON INVOLVEMENT

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[885.0 - 885.1](#) TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) COMPLICATED

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- [890.0](#) - OPEN WOUND OF HIP AND THIGH WITHOUT  
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- [891.0](#) - OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND  
[891.2](#) ANKLE WITHOUT COMPLICATION - OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE WITH TENDON INVOLVEMENT
- [892.0](#) - OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITHOUT  
[892.2](#) COMPLICATION - OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITH TENDON INVOLVEMENT
- [893.0](#) - OPEN WOUND OF TOE(S) WITHOUT COMPLICATION -  
[893.2](#) OPEN WOUND OF TOE(S) WITH TENDON INVOLVEMENT
- [895.0](#) - TRAUMATIC AMPUTATION OF TOE(S) (COMPLETE)  
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- V52.0 FITTING AND ADJUSTMENT OF ARTIFICIAL ARM (COMPLETE) (PARTIAL)
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### **General Information**

#### **Documentation Requirements** [back to top](#)

For documentation requirements see the following reference: Medicare Benefit Policy Manual (Pub 100-2), Chapter 7, Section 40.2. Additional documentation requirements may be found under the appropriate CPT/HCPC code, at: [www.cms.hhs.gov](http://www.cms.hhs.gov)

#### **General Information**

To qualify for the Medicare home health PPS benefit, under Sections 1814(a)(2)(C) and 1835(a)(2)(A), a Medicare beneficiary must meet the following requirements, which should be documented:

- Be confined to the home
- Under the care of a physician
- Receiving services under a plan of care established and periodically reviewed by a physician
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or have a continued need for occupational therapy

#### **Physical Therapy Services**

Skilled physical therapy services are reimbursable under Medicare if the services are documented as being:

- Ordered by a physician
- Provided by a skilled physical therapist, or under the general supervision

of a skilled physical therapist

- Reasonable and necessary to the treatment of the illness or injury, or to the restoration or maintenance of function affected by the illness or injury
- Provided as a result of a valid, written, physician's signed and dated plan of treatment. The plan of treatment is established prior to the provision of physical therapy services and outlines the type, amount, frequency, and duration of the physical therapy services to be provided, identifies the functional diagnosis deficits, and anticipates the short and long term goals to be accomplished
- In accordance with the above guidelines as set forth in this LCD

### **Signature Requirements**

Medicare requires a legible identity for services provided/ordered. The method used may be hand-written, electronic, or signature stamp; subject to state laws. The individual whose name is on the alternate signature method bears the responsibility for authenticity.

### **Treatment Notes**

- Treatment notes should be completed per visit. They should be legible and clearly relate back to the established goals. Symbols, acronyms, and notation used in treatment notes should be:
  - Consistent with standard documentation
  - Discernable, either on their face (e.g. PT = Physical Therapy), or by supplied legends
  - Objective (e.g., 3/10 for pain)
- Treatment notes should readily reflect all services billed
- Failure of treatment notes to meet the above may result in non-coverage

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**Utilization Guidelines** [back to top](#)

This LCD should be interpreted to incorporate future changes in the ICD-9-CM or CPT/HCPCS coding systems such that its original intent and scope will not be

substantively changed.

- **Utilization Guidelines**  
Throughout the LCD are stated utilization guidelines (i.e., number of visits), and **DO NOT** imply coverage or non-coverage of a service. Services must be reasonable and necessary for each individual and be supported by the plan of care and other documentation.
- **Programs**  
Medicare does not cover "packaged" or "constellation of predetermined" services (i.e., "programs"). Services must be individualized and reasonable and necessary for each beneficiary.
- **Qualified Personnel**  
Medicare does not pay for the services provided by aides/technicians regardless of the level of supervision. Medicare pays only for services delivered by qualified physical therapists and physical therapy assistants.

#### Sources of Information and Basis for Decision [back to top](#)

- APTA website [www.apta.org](http://www.apta.org)
- Guide to Physical Therapist Practice, APTA, 2nd Ed., 2003
- Physical Therapist's Clinical Companion; Springhouse Corporation
- Documenting Physical Therapy; Baeten, Moran, Phillips
- Reimbursement for Rehabilitation Services; APTA Seminar; Helene M. Fearon, P.T., presenter
- Serial Casting: Principles and Experiences; Christiansen
- Randomized control trial of vestibular rehabilitation combined with cognitive - behavioral therapy for dizziness in older people; Johansson et al.; Otololaryngology Head and Neck Surgery 2001 Sept; 1245 (3): 151-
- Increased independence and decreased vertigo after vestibular rehabilitation; Cohen, H; Kimball K; Otololaryngology Head and Neck Surgery 2003 Jan; 128 (1): 60-70
- Vestibular rehabilitation: Useful but not universally so; Otololaryngology Head and Neck Surgery 2003 Feb; 128(2): 240-50

- Strategies for Balance Rehabilitation; Herdman, S. et al.; Annals of the New York Academy of Sciences; 2001 Oct; 942:394-412
- Improvements in path integration after vestibular rehabilitation; Cohen; Kimball; Journal Vestibular Research; 2002; 12(1): 47-51
- Dizziness; The Medical Clinics of North America; 87 (2003) 609-641; Tusa, MD, PhD
- Sports Medicine for the Primary Care Physician (Second edition); Birrer, R.; Boca Raton: CRC Press; 1994
- Rehabilitation Medicine: Principles and Practice; DeLisa, J. and Gans, B. (Eds); Philadelphia: J.B. Lippincott Company; 1993
- Krusen's Handbook of Physical Medicine and Rehabilitation (4th edition); Kottke, F. and Lehmann, J. (Eds); Philadelphia: W.B. Saunders Company; 1990
- Principles of Rehabilitation in Older Patients; Studenski, S., Duncan, P., Maino, J.; Principles of Geriatric Medicine and Gerontology; Hazzard WR, Blass JP, Ettinger WH et al (Eds); The McGraw Hill Companies, Inc., 1999
- Other Contractor Policies

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This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from other Intermediaries and other Intermediary Providers.

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#### **End Date of Comment Period** [back to top](#)

10/08/2006

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02/01/2007

**Revision History Number** [back to top](#)

n/a

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**02/01/2007**

The RHHI draft LCD, "Physical Therapy - Home Health" has been finalized and can be viewed at [www.cahabagba.com](http://www.cahabagba.com)

Following the notice period, which begins February 1, 2007, the LCD will become effective April 1, 2007. Comments and responses may be found in the "Related Documents" section of the draft LCD.

Please update your records.

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**Related Documents** [back to top](#)

This LCD has no Related Documents.




**LCD Attachments** [back to top](#)

There are no attachments for this LCD.

**Read the [LCD Disclaimer](#)**

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