Physical Therapy

I. Policy

University Health Alliance (UHA) will reimburse for physical therapy when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Physical therapy (the treatment of disease or injury using therapeutic exercise and other interventions that focus on range of motion, improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and on alleviating pain and integrates all of the above so a patient may regain functional activities of daily living) is covered (subject to Limitations/Exclusions and Administrative Guidelines) only if services meet all of the following criteria:

1. Therapy is necessary to treat function lost or impaired by disease or trauma, congenital anomalies (structural malformation) or prior therapeutic intervention.
2. Therapy is ordered by a practitioner acting within the scope of his/her license who has also established the patient's diagnosis.
3. Therapy requires the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the physical condition of the patient. A qualified provider is one who is licensed where required, performs within the scope of licensure, and is recognized by UHA.
4. Therapy meets the functional needs of a patient who suffers from physical impairment due to disease or trauma, congenital anomalies (structural malformation), or prior therapeutic intervention and is necessary to sufficiently restore or improve neurological and/or musculoskeletal function. Neurological and/or musculoskeletal function is sufficiently restored when one of the following first occurs:
   a. Neurological and/or musculoskeletal function is the level of the average healthy person of the same age; or
   b. When improvement beyond what is expected with activities of daily living, prescribed home exercise, and passage of time, is unlikely.
5. The purpose of the therapy is to achieve a specific diagnosis-related goal for a patient who has a reasonable expectation of achieving significant improvement in a reasonable and predictable period of time.
   a. Significant is defined as a measurable and meaningful increase (as documented in the patient's record) in the patient's level of physical and functional abilities that can be attained with short-term therapy, usually within a three month period.
6. The therapy must include a home exercise/education program to be initiated at the first physical therapy visit. The physical therapist must document the patient's participation in and compliance with the home exercise/education program. The home program must be explicitly emphasized at every visit.
7. Therapy is used to achieve significant, meaningful functional improvement through specific diagnosis-related goals documented in an individualized, written treatment plan of care with measurable objectives that include:

a. Range of motion (musculoskeletal)

b. Motor exam

c. Functional abilities (skills and deficits)

B. Modalities defined by CPT as requiring constant attendance or direct one-on-one patient contact, must be provided by the licensed physical therapist using constant, direct, one-on-one patient contact.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Physical therapy benefits are not available for the following:

1. Leisure activities including hobbies, sports, or recreation of all types even if suggested as part of a PT treatment plan. This includes continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform activities of daily living; it is **NOT** intended to return the individual to their previous (or improved) level of sports competition or capability;
2. Ongoing treatment solely to improve endurance and distance;
3. General exercise programs to promote overall fitness;
4. Programs to provide diversion or general motivation;
5. Long term therapy;
6. Group exercise/therapy programs: defined as the simultaneous treatment of two or more patients who may or may not be doing the same activities;
7. Developmental delay defined as any significant lag in a child's physical, cognitive, behavioral, emotional, or social development, in comparison with norms; or

B. Kinesio taping.

C. Up to four procedures and/or modalities per visit are allowed (not to exceed one hour). Modalities and procedures must meet payment determination criteria and are subject to review.

D. Application of hot or cold packs (CPT 97010) is bundled into the payment for other services and is not separately payable.

E. Iontophoresis (CPT 97033), infrared (97026), ultraviolet modalities (97028), and laser therapy (97039, HCPCS S8948) do not meet payment determination criteria as there is no evidence based on published, controlled clinical studies which demonstrate their efficacy.

F. Work hardening and community work integration programs (CPT 97545, 97546, 97537) and functional capacity assessments (CPT 97750) do not meet payment determination criteria as these services are

intended for the purpose of testing or conditioning for return to work, rather than treatment for a medical condition.

G. Duplicate therapy is not covered. When a patient receives both occupational and physical therapy, the therapies should provide different treatments and not duplicate the same treatment. However, total treatment session limitations are combined for physical and occupational therapy (i.e., no more than a total of 32 units). They must have separate treatment plans and goals with treatment occurring in separate treatment sessions and visits. This includes:

    1. Duplicate services available through schools and government programs. Physical therapy may be available under a child's individualized education program (IEP). An IEP should be completed before requesting coverage through UHA.

H. Non-skilled services which do not require the intervention of a qualified provider of physical therapy services are not covered, such as:

    1. Services that include any of the following treatments given alone or to patient who presents no complications: hydrocollator; whirlpool baths; paraffin baths; Hubbard tank; and contrast baths.

    2. Procedures that may be carried out effectively by the patient, family, or caregivers.

I. Certain types of therapy (e.g., passive range of motion treatment not related to restoration of a specific loss of function by using routine, repetitive, and reinforced procedures which do not require one-to-one intervention such as stationary bike riding without any intervention) do not generally require the skills of a qualified provider of PT services and are therefore not covered.

J. Maintenance programs are not covered. Maintenance programs are defined as activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent.

K. Services provided by students, PT aides, or other non-qualified professionals are not covered. This includes but is not limited to personnel (such as athletic coaches, athletic trainers or personal trainers) who may or may not be supervised by physicians, physical therapists, or other licensed providers.

    1. Physical therapy is only covered when provided by a qualified provider. A qualified provider is one who is licensed in the practice of Physical Therapy and performs within the scope of licensure.

L. If the patient requires skilled therapy for multiple body sites (e.g. shoulder and knee, bilateral shoulders, etc.) a visit should include all treatment necessary.

M. Physical therapy benefits are not available to treat conditions which are otherwise excluded from coverage under the member's plan.

N. For any single timed CPT code used on the same day and measured in 15 minute units, providers must bill a single 15-minute unit for treatment for greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 4 units are as follows:

    1. 1 unit: ≥ 8 minutes through 22 minutes

    2. 2 units: ≥ 23 minutes through 37 minutes

    3. 3 units: ≥ 38 minutes through 52 minutes

    4. 4 units: ≥ 53 minutes through 67 minutes

IV. Administrative Guidelines

A. Prior authorization is required after 8 visits or 32 units combined OT and PT per calendar year. All prior authorizations submitted will be reviewed for medical necessity.

B. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

C. Providers of physical therapy services must confirm whether the patient has previously received services for physical therapy from another PT/OT provider.

D. Documentation submitted must include an individualized, written treatment plan appropriate for the diagnosis, symptoms and findings of the physical therapy evaluation which clearly documents the medical necessity of the treatment.

   1. Specific statements of goals including a transition from one-to-one supervision to a patient, family member, or caregiver upon discharge to a home maintenance program.
   2. Measurable objectives intended to facilitate meaningful functional improvement.
   3. A reasonable estimate of when the goals will be reached.
   4. The specific procedures and/or modalities to be used in treatment including those for use in a home maintenance program.
   5. The frequency and duration of the treatment.
   6. A treatment plan should be appropriately revised as the patient's condition changes.

E. The frequency of visits should be appropriate according to the patient's physical condition and stage of healing.

F. Definitions:

   1. Activities of daily living: Normal activities of daily living such as toileting, feeding, dressing, grooming, bathing, etc.
   2. Assessment: Assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). For example, assessment determines changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on this assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or reevaluation is indicated. Assessment is included in services/procedures and is not separately payable (as distinguished from CPT codes that specify assessment).
   3. Evaluation: Evaluation is a comprehensive service that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. For example, an evaluation is warranted for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of a plan of care, with goals and interventions. The time spent performing an evaluation does not also count as treatment time. Evaluation services are separately payable.
   4. Reevaluation: Reevaluation requires the same professional skills as an evaluation and is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline, or change in a patient's condition or physical status. A reevaluation is focused on evaluating progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. The reevaluation CPT code can only be used under the following circumstances: a

significant change in the patient's condition requiring a new treatment plan; the patient is not responding to the current treatment plan; or new findings will significantly affect the current treatment plan. The reevaluation CPT code is not a covered code when used: for periodic reassessments; when creating a progress summary note for a physician; and for routine pre- and post-service assessments. These services are not separately reimbursable as reevaluations and should be included in the time rendered for the procedure.

CPT Code	Description
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and

	Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

HCPCS Code	Description
S8950	Complex lymphedema therapy, each 15 minutes

V. Policy History

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