


MEDICAL POLICY	Outpatient Physical Therapy
<p><b>Effective Date: 10/1/2021</b></p>  <p style="text-align: right;">10/1/2021</p>	<p>Medical Policy Number: 245</p>
<p>Medical Officer                      Date</p>	<p>Medical Policy Committee Approved Date: 11/17; 12/18; 12/19; 9/2020; 09/2021</p>

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All lines of business

**BENEFIT APPLICATION**

Medicaid Members

*Oregon:* Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**POLICY CRITERIA**

Notes:

- Physical therapy documentation is expected to include objective verification of measured, progressive functional improvement, or lack of improvement, within the specified duration of time prescribed for the condition being treated. Lack of documentation may result in non-coverage of physical therapy services.
- This policy ONLY addresses physical therapy services requested to treat musculoskeletal or chronic pain.
- This policy does not address physical therapy services in patients 17 years old or younger or in patients with cerebrovascular disease with neurological deficit.
- This policy is for concurrent or retrospective review of services only.

*Medically Necessary*

- I. Outpatient physical therapy, in patients 18 years or older, may be considered **medically necessary and covered** as a treatment of musculoskeletal pain or chronic pain conditions, when **all** of the following criteria are met (A. –M.):
- A. Physical therapy services are prescribed by a licensed physician or other licensed healthcare practitioner; **and**
  - B. Physical therapy services are performed by a licensed physical therapist or other qualified healthcare practitioner acting within the scope of their license; **and**
  - C. Physical therapy services are provided under the ongoing direction and supervision of a licensed physical therapist; **and**
  - D. Physical therapy services are prescribed as treatment of a specific condition or injury; **and**
  - E. The physical therapy plan meets currently accepted standards of medical practice which are specific and effective for the given condition being treated; **and**
  - F. Physical therapy services are of such a level of complexity or the condition of the patient is such that the services required can be safely and effectively performed only by, or require the supervision of, a physical therapist; **and**
  - G. The prescribed physical therapy intervention and frequency are based on the examination, evaluation, diagnosis, prognosis, and are appropriate for the condition being treated; **and**
  - H. The time period, duration, and frequency of the prescribed physical therapy plan is clearly defined and reasonable, based on the condition being treated; **and**
  - I. The physical therapy plan includes goals and expected outcomes within the prescribed frequency and duration of treatment; **and**
  - J. Documentation provides ongoing review and evaluation of physical therapy services. Physical limitations, goals, and progress must be documented; **and**
  - K. Physical therapy services have demonstrated significant, progressive improvement in functional level related to the condition being treated; **and**
  - L. Physical therapy service do not duplicate those provided concurrently by any other therapy; **and**
  - M. A patient’s functional level is **not** reasonably expected to improve with **any** of the following treatments, if applicable (1.-3.):
    - 1. A gradual return to activities of daily living; **or**
    - 2. Rest of the injured area; **or**
    - 3. Anti-inflammatory medication.

*Not Medically Necessary*

- II. Outpatient physical therapy services, in patients 18 years or older, is considered **not medically necessary and is not covered** as a treatment of musculoskeletal pain or chronic pain conditions when criteria I. above is not met, including, but not limited to any of the following (A.-G.):
- A. The patient is unable to continue to progress toward goals as outlined in the physical therapy plan;
  - B. There is no reasonable benefit which can be expected through continuation of physical therapy service;
  - C. Physical therapy services offered to solely to improve athletic performance;

- D. Physical therapy services which are not expected to improve a patient’s activities of daily living;
- E. Passive or repetitive therapies which reinforce previously learned skills or do not require skilled one-to-one intervention (example: stationary bike riding);
- F. Group exercise programs which simultaneously include two or more patients;
- G. Mobile applications/web-based physical therapy management software (e.g. Mobaflex, VERA system).

Link to [Policy Summary](#)

## CPT/HCPCS CODES

All Lines of Business	
No Prior Authorization Required	
Note: Physical therapy service codes may include, but are not limited to, the following:	
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97026	Application of a modality to 1 or more areas; infrared
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)
97140	Manual therapy techniques (eg, 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

MEDICAL POLICY	Outpatient Physical Therapy
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
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved
98926	Osteopathic manipulative treatment (OMT); 3-4 body regions involved

MEDICAL POLICY	Outpatient Physical Therapy
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98927	Osteopathic manipulative treatment (OMT); 5-6 body regions involved
98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions
S9131	Physical therapy; in the home, per diem
Not Covered	
97150	Therapeutic procedure(s), group (2 or more individuals)
<b>Unlisted Codes</b> All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then <b>prior-authorization is required.</b>	
97039	Unlisted modality (specify type and time if constant attendance)
97139	Unlisted therapeutic procedure (specify)
97799	Unlisted physical medicine/rehabilitation service or procedure

**DESCRIPTION**

Physical therapy (PT), also known as physiotherapy, is a treatment which aims to improve an illness or injury that limit a patient’s ability to move and perform functional activities of daily living (ADLs). According to the American Physical Therapy Association, “Physical therapists are health care professionals who help individuals maintain, restore, and improve movement, activity, and functioning, thereby enabling optimal performance and enhancing health, well-being, and quality of life. Their services prevent, minimize, or eliminate impairments of body functions and structures, activity limitations, and participation restrictions.”<sup>1</sup>

Providers specializing in PT utilize patient history, perform a physical exam, and may review imaging to assess a patient’s condition and develop a treatment plan. Physical therapy treatment may include mechanical force and movements (kinesiology), manual therapy, exercise therapy, etc., to promote improvements in mobility, function, and quality of life scores.

There are a variety of physical therapy specialty areas which include, but are not limited to, geriatric, palliative care, neurological, orthopedic, sports, pediatric, and back pain. This focus of this policy is on musculoskeletal pain and back pain which may encompass the specialty areas of orthopedic, sports, and back pain.

**REVIEW OF EVIDENCE**

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of physical therapy as a treatment of musculoskeletal conditions. Below is a summary of the available evidence identified through August 2021.

**Physical Therapy**

In 2007, Taylor et al. conducted a systematic review of the evidence to evaluate therapeutic exercise.<sup>2</sup> Specifically, the authors wanted to summarize previously published systematic reviews and determine if therapeutic exercise is beneficial to patients consulting with a physiotherapist. Independent reviewers systematically identified eligible studies, assessed quality, and extracted data. Study authors were also contacted, if necessary, for additional information or data. The primary outcome of interest was the effect of therapeutic exercise in terms of impairment, activity limitations, or participation restriction.

Following systematic review, the authors identified 38 systematic reviews as eligible for inclusion. All studies were determined to be of moderate or good quality. In regard to therapeutic exercise for arthritis, the authors concluded “strong evidence that therapeutic exercise can benefit people with osteoarthritis of the knee and moderate level evidence that therapeutic exercise can benefit people with ankylosing spondylitis.”<sup>2</sup> The authors also evaluated therapeutic exercise for back pain and concluded, “therapeutic exercise was effective compared to no treatment in subacute and chronic low back pain and after lumbar disc surgery, but not for patients with acute low back pain.”<sup>2</sup> The authors identified “strong evidence that therapeutic exercise when combined with manual therapy can benefit people with mechanical neck disorders, and moderate or limited evidence that therapeutic exercise can benefit people with neck-related headaches and whiplash associated disorders.”<sup>2</sup> There was insufficient or limited evidence to support therapeutic exercise following fractures or musculoskeletal disorder of the lower or upper limbs.

Strengths of this systematic review include the gathering of evidence, assessment of quality, and extraction of data by several independent reviewers, large sample size, and assessment of heterogeneity. Limitations were identified in the small number of selected studies (possible publication bias) and inability to conduct meta-analyses due to significant inter-study heterogeneity. The authors concluded, “(t)herapeutic exercise was beneficial for patients across broad areas of physiotherapy practice.”<sup>2</sup>

## Hip

In 2014 (updated 2018; archived 2019), Hayes conducted an evidence review to evaluate preoperative physical therapy for severe osteoarthritis (OA) of the hip.<sup>3</sup> The review included eight peer-reviewed randomized controlled trials (RCTs) with sample sizes ranging from 21 to 84 patients with severe OA scheduled to undergo total hip arthroplasty (THA). The outcome measures included various health surveys and mobility measures and follow-up times ranged from 6 days to 2 years.

Overall, Hayes gave the following conclusions:

- Self-reported and observed measures of function and mobility were improved in some studies.
- Objective measures of hip range of motion (ROM) and muscle strength were improved in some studies.
- There is very limited evidence that preoperative physical therapy decreases pain and decreases hospital length of stay (LOS) following surgery.
- Preoperative exercise-based physical therapy is a safe procedure and complications are rare and nonserious.
- Although approximately half of the studies included an education component in addition to the exercise intervention, there was no systematic effect found on patient outcomes.

However, the evidence was conflicting and the quality of evidence was determined to be low due to small sample sizes, short follow-up, and lack of standardized and validated physical therapy programs. Ultimately, Hayes concluded a C rating for preoperative exercise-based physical therapy in adult patients with severe OA who are scheduled for THA. This conclusion is based on “some positive but conflicting evidence for beneficial effects of preoperative physical therapy for patients with severe osteoarthritis (OA).”<sup>3</sup>

## Knee

- In 2014 (updated 2018; archived 2019), Hayes conducted an evidence review to evaluate preoperative physical therapy for severe osteoarthritis (OA) of the knee.<sup>4</sup> The review included 13 peer-reviewed randomized controlled trials (RCTs). Sample sizes ranging from n=22 to n=181, and included patients with severe OA scheduled to undergo total knee arthroplasty (TKA) or unicompartmental knee replacement (UKR). The outcome measures included various health surveys and mobility measures and follow-up times ranged from 6 weeks to 12 months.

Overall, Hayes gave the following conclusions:

- Self-reported and observed measures of function and mobility were not improved in most studies. Any beneficial effects observed may be attributed to serious limitations in the studies (e.g., inappropriate statistical analyses).
- Objective measures of hip range of motion (ROM) and muscle strength were not improved in the majority of the studies.
- Preoperative physical therapy does not decrease pain or hospital length of stay (LOS) following surgery.
- Preoperative physical therapy does not increase the speed of recovery following surgery.
- Preoperative exercise-based physical therapy is a safe procedure and complications are rare and nonserious.

The overall quality of evidence was determined to be low due to small sample sizes, short follow-up, lack of standardized and validated physical therapy programs, and lack of standardized outcome measures. Ultimately, Hayes concluded a D1 rating “for preoperative exercise-based physical therapy in adult patients with severe osteoarthritis (OA) scheduled for total knee arthroplasty (TKA) or unicompartmental knee replacement (UKR).”<sup>4</sup>

- In 2012, the Agency for Healthcare Research and Quality (AHRQ) conducted a systematic review and meta-analysis to “assess the association between intermediate and patient-centered outcomes and harms with physical therapy interventions in community-dwelling adults with chronic knee pain secondary to osteoarthritis and to examine validity and minimum clinically important differences of the tools for outcome measurement.”<sup>5</sup> Independent reviewers systematically identified eligible studies, assessed quality, and extracted data. Study authors were also contacted, if necessary, for additional information or data. The primary outcomes of interest were pain, physical function, and disability.

The authors identified 84 randomized controlled trials (RCTs) that were eligible for inclusion. These RCTs evaluated 12 physical therapy interventions on pain (n=58), physical function (n=36), and

disability (n=29). “Meta-analyses at the longest time of follow-up provided low-strength evidence that aerobic (n = 11) and aquatic exercise (n = 3) improved disability; aerobic exercise (n = 19), strengthening exercise (n = 17), and ultrasound (n = 6) reduced pain and improved function.”<sup>5</sup> Of 11 RCTs, 6 demonstrated clinically significant improvements in pain and disability with aerobic exercise. Furthermore, pain relief was consistent in RCTs that reported physical therapist supervision of aerobic exercise. “Evidence from individual RCTs did not permit robust conclusions about which physical therapy interventions are most effective or whether differences in effect could be attributed to patient characteristics.”<sup>5</sup> Although, patients with high compliance to exercise had better treatment response. There was no association between the duration of physical therapy and better or intermediate patient-centered outcomes.

This AHRQ systematic review was of very good quality and had several strengths, including:

1. the gathering of evidence, assessment of quality, and extraction of data by several independent reviewers
2. contacting authors of selected studies for additional information or data
3. assessment of heterogeneity and publication bias
4. meta-analyses only being conducted when studies were determined to be homogeneous with respect to population, treatment, and outcome measures
5. sensitivity analyses to evaluate the influence of studies with a high risk of bias or high losses to follow-up

Limitations of this systematic review are seen in the inclusion of studies with a high risk of bias and the potential for publication bias. The authors concluded, “(l)ow-strength evidence suggested that core physical therapy interventions, including aerobic, aquatic, strengthening, and proprioception exercise, improved patient outcomes.”<sup>5</sup>

## Shoulder

- In 2016, Page et al. conducted a Cochrane systematic review to “synthesize available evidence regarding the benefits and harms of manual therapy and exercise, alone or in combination, for the treatment of people with rotator cuff disease.”<sup>6</sup> Independent reviewers systematically identified eligible studies, assessed quality, and extracted data. Study authors were also contacted, if necessary, for additional information or data. The primary outcomes of interest were overall pain, function, pain on motion, patient-reported global assessment of treatment success, quality of life and the number of participants experiencing adverse events.

The authors identified 60 trials encompassing 3,620 participants as eligible for inclusion. Overall risk of bias was determined to be low in three trials, unclear in 14 trials, and high in 43 trials. “Despite identifying 60 eligible trials, only one trial compared a combination of manual therapy and exercise reflective of common current practice to placebo.”<sup>6</sup> In this trial (determined to be of high quality), patients showed more improvement in overall pain with manual therapy and exercise compared to placebo. Furthermore, “fifty-seven per cent (31/54) of participants reported treatment success with manual therapy and exercise compared with 41% (24/58) of participants receiving placebo.”<sup>6</sup> Five trials, of low quality, found no important differences between manual therapy and exercise compared to glucocorticoid injection. One trial (low quality) found no important differences between manual therapy and exercise compared to subacromial decompression. Fifty-two trials



(low quality) evaluated the effects of manual therapy alone or exercise alone and found little or no differences in patient-important outcomes.

This Cochrane systematic review was of very good quality and had several strengths, including:

1. the gathering of evidence, assessment of quality, and extraction of data by several independent reviewers
2. contacting authors of selected studies for additional information or data
3. assessment of heterogeneity and publication bias
4. sensitivity analyses to evaluate the influence of studies with a high risk of bias or high losses to follow-up

Limitations include the inability to perform meta-analysis due to clinical heterogeneity or incomplete outcome reporting, and only one study that compared manual therapy and exercise reflective of common current practice. Ultimately, the authors concluded “(e)ffects of manual therapy and exercise may be similar to those of glucocorticoid injection and arthroscopic subacromial decompression, but this is based on low quality evidence.”<sup>6</sup>

- In 2003, Green and colleagues conducted a Cochrane systematic review to evaluate physiotherapy interventions for shoulder pain.<sup>7</sup> Independent reviewers systematically identified eligible studies, assessed quality, and extracted data. Study authors were also contacted, if necessary, for additional information or data. The primary outcomes of interest were improvements in pain, stiffness, and disability.

Following systematic review, the authors identified 26 trials as eligible for inclusion. Methodological quality was variable and sample sizes ranged from n = 14 to n = 180. A total of fourteen studies compared a physiotherapy modality to placebo, while eight trials compared one physiotherapy modality to another. A supervised exercise regimen demonstrated to be of significant benefit in the short and long term. Two trials demonstrated sustained significant benefit for exercise over placebo with respect to recovery, function, and range of motion. Specifically, “(e)xercise was demonstrated to be effective in terms of short term recovery in rotator cuff disease (RR 7.74 (1.97, 30.32), and longer term benefit with respect to function (RR 2.45 (1.24, 4.86)).”<sup>7</sup> Furthermore, combining mobilization with exercise was more effective than exercise alone.

This Cochrane systematic review was of very good quality and had several strengths, including:

5. the gathering of evidence, assessment of quality, and extraction of data by several independent reviewers
6. contacting authors of selected studies for additional information or data
7. assessment of heterogeneity and publication bias
8. meta-analyses only being conducted when studies were determined to be homogeneous with respect to population, treatment, and outcome measures

Limitations are present in the poor quality of selected studies, including small sample sizes and short follow-up periods. Ultimately, the authors concluded “(t)here is some evidence from methodologically weak trials to indicate that some physiotherapy interventions are effective for some specific shoulder disorders.”<sup>7</sup>

## CLINICAL PRACTICE GUIDELINES

### American Academy of Orthopedic Surgeons (AAOS)

- The 2017 AAOS evidence-based clinical practice guideline on the management of osteoarthritis (OA) of the hip gave the following recommendations:

“Physical Therapy as a Conservative Treatment: Strong evidence supports the use of physical therapy as a treatment to improve function and reduce pain for patients with osteoarthritis of the hip and mild to moderate symptoms. Strength of Recommendation: Strong Evidence.

Preoperative Physical Therapy: Limited evidence supports the use of preoperative physical therapy to improve early function in patients with symptomatic osteoarthritis of the hip following total hip arthroplasty. Strength of Recommendation: Limited Evidence.

Postoperative Physical Therapy: Moderate evidence supports the use of post-operative physical therapy because it could improve early function to a greater extent than no physical therapy management for patients with symptomatic osteoarthritis of the hip who have undergone total hip arthroplasty. Strength of Recommendation: Moderate Evidence.”<sup>8</sup>

- The 2014 AAOS evidence-based clinical practice guideline on the management of hip fractures in the elderly gave the following recommendations:

“Occupational and Physical Therapy: Moderate evidence supports that supervised occupational and physical therapy across the continuum of care, including home, improves functional outcomes and fall prevention. Strength of Recommendation: Moderate.

Intensive Physical Therapy: Strong evidence supports intensive physical therapy post-discharge to improve functional outcomes in hip fracture patients. Strength of Recommendation: Strong.”<sup>9</sup>

- The 2014 AAOS evidence-based clinical practice guideline on the management of anterior cruciate ligament injuries gave the following recommendations:

“ACL Post-op Physical Therapy: For those undergoing post-operative rehabilitation after ACL reconstruction, moderate evidence supports early, accelerated, and non-accelerated protocols because they have similar outcomes. Strength of Recommendation: Moderate.”<sup>10</sup>

### American Physical Therapy Association (APTA)

In 2014, the APTA published standards of practice guideline for physical therapy and made the following recommendations:<sup>11</sup>

#### Administration of the Physical Therapy Services

Criteria regarding the documentation of an improvement plan, state:

##### “Improvement of Quality of Care and Performance

The physical therapy service has a written plan for continuous improvement of quality of care and performance of services.

##### *The improvement plan:*

- *Provides evidence of ongoing review and evaluation of the physical therapy service.*
- *Provides a mechanism for documenting improvement in quality of care and performance.*
- *Is consistent with requirements of external agencies, as applicable.”*

#### Patient/Client Management

Criteria regarding the initial examination, evaluation, diagnosis, and prognosis, state:

##### *“The physical therapist examination:*

- *Is documented, dated, and appropriately authenticated by the physical therapist who performed it.*
- *Identifies the physical therapy needs of the patient/client.*
- *Incorporates appropriate tests and measures to facilitate outcome measurement.*
- *Produces data that are sufficient to allow evaluation, diagnosis, prognosis, and the establishment of a plan of care.*
- *May result in recommendations for additional services to meet the needs of the patient/client.”*

Criteria regarding the plan of care, state:

##### “Plan of Care

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

The physical therapist involves the patient/client and appropriate others in the planning, anticipated goals and expected outcomes, proposed frequency and duration, and implementation of the plan of care.

##### *The plan of care:*

- *Is based on the examination, evaluation, diagnosis, and prognosis.*

- *Identifies goals and outcomes.*
- *Describes the proposed intervention, including frequency and duration.*
- *Includes documentation that is dated and appropriately authenticated by the physical therapist who established the plan of care."*

Criteria regarding the plan physical therapy intervention, state:

#### "Intervention

The physical therapist provides or directs and supervises the physical therapy intervention consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care. The physical therapy intervention may be provided in an episode of care, or in a single visit/encounter such as for a wellness and prevention visit/encounter or a specialty consultation or for a follow-up visit/encounter after episodes of care, or may be provided intermittently over longer periods of time in cases of managing chronic conditions.

An *episode of care* is the managed care provided for a specific problem or condition during a set time period and can be given either for a short period or on a continuous basis, or it may consist of a series of intervals marked by 1 or more brief separations from care.

#### *The intervention:*

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

Criteria regarding reexamination, state:

#### "Reexamination

The physical therapist reexamines the patient/client as necessary during an episode of care, during follow-up visits/encounters after an episode of care, or periodically in the case of chronic care management, to evaluate progress or change in patient/client status. The physical therapist modifies the plan of care accordingly or concludes the episode of care.

#### *The physical therapist reexamination:*

- *Is documented, dated, and appropriately authenticated by the physical therapist who performs it.*

- *Includes modifications to the plan of care.”*

Criteria regarding the conclusion of care, state:

“Conclusion of Episode of Care

The physical therapist concludes an episode of care when the anticipated goals or expected outcomes for the patient/client have been achieved, when the patient/client is unable to continue to progress toward goals, or when the physical therapist determines that the patient/client will no longer benefit from physical therapy.

*Conclusion of care documentation:*

- *Includes the status of the patient/client at the conclusion of care and the goals and outcomes attained.*
- *Is dated and appropriately authenticated by the physical therapist who concluded the episode of care.*
- *Includes, when a patient/client is discharged prior to attainment of goals and outcomes, the status of the patient/client and the rationale for discontinuation.*

Criteria regarding client management, state:

“Communication/Coordination/Documentation

The physical therapist communicates, coordinates, and documents all aspects of patient/client management including the results of the initial examination and evaluation, diagnosis, prognosis, plan of care, intervention, responses to intervention, changes in patient/client status relative to the intervention, reexamination, and episode of care summary. The physical therapist of record is responsible for “hand off” communication.

*Physical therapist documentation:*

- *Is dated and appropriately authenticated by the physical therapist who performed the examination and established the plan of care.*
- *Is dated and appropriately authenticated by the physical therapist who performed the intervention or, when allowable by law or regulations, by the physical therapist assistant who performed specific components of the intervention as selected by the supervising physical therapist.*
- *Is dated and appropriately authenticated by the physical therapist who performed the reexamination, and includes modifications to the plan of care.*
- *Is dated and appropriately authenticated by the physical therapist who performed the episode of care summary and includes the status of the patient/client and the goals and outcomes achieved.*
- *Includes, when a patient’s/client’s care is concluded prior to achievement of goals and outcomes, the status of the patient/client and the rationale for conclusion of care.*
- *As appropriate, records patient data using a method that allows collective analysis.”<sup>11</sup>*

### Heel Pain

The 2014 APTA evidence-based clinical practice guideline for the management of heel pain—plantar fasciitis gave the following recommendation:

“Clinicians should use manual therapy, consisting of joint and soft tissue mobilization, procedures to treat relevant lower extremity joint mobility and calf flexibility deficits and to decrease pain and improve function in individuals with heel pain/plantar fasciitis. (Grade of Recommendation: A)”<sup>12</sup>

### Ankle Stability and Movement Coordination

The 2013 APTA evidence-based clinical practice guideline for ankle stability and movement coordination impairments gave the following recommendations:

“Manual Therapy: Clinicians should use manual therapy procedures, such as lymphatic drainage, active and passive soft tissue and joint mobilization, and anterior-to-posterior talar mobilization procedures, within pain-free movement, to reduce swelling, improve pain-free ankle and foot mobility and normalize gait parameters in individuals with an acute lateral ankle sprain. (Grade of Recommendation B).

Therapeutic Exercises: Clinicians should implement rehabilitation programs that include therapeutic exercises for patients with severe lateral ankle sprains. (Grade of Recommendation A).

Sport-Related Activity Training: Clinicians can implement balance and sport-related activity training to reduce the risk for recurring ankle sprains in athletes. (Grade of Recommendation C).”<sup>13</sup>

### Low Back Pain

The 2012 APTA evidence-based clinical practice guideline for low back pain gave the following recommendations:

“Manual Therapy: Clinicians should consider utilizing thrust manipulative procedures to reduce pain and disability in patients with mobility deficits and acute low back and back-related buttock or thigh pain. Thrust manipulative and nonthrust mobilization procedures can also be used to improve spine and hip mobility and reduce pain and disability in patients with subacute and chronic low back and back-related lower extremity pain. (Grade of Recommendation A).

Trunk Coordination, Strengthening, and Endurance Exercises: Clinicians should consider utilizing trunk coordination, strengthening, and endurance exercises to reduce low back pain and disability in patients with subacute and chronic low back pain with movement coordination impairments and in patients post-lumbar microdiscectomy. (Grade of Recommendation A).

Centralization and Directional Preference Exercises and Procedures: Clinicians should consider utilizing repeated movements, exercises, or procedures to promote centralization to reduce symptoms in patients with acute low back pain with related (referred) lower extremity pain. Clinicians should consider using repeated exercises in a specific direction determined by treatment

response to improve mobility and reduce symptoms in patients with acute, subacute, or chronic low back pain with mobility deficits. (Grade of Recommendation A).

Progressive Endurance Exercise and Fitness Activities: Clinicians should consider (1) moderate- to high-intensity exercise for patients with chronic low back pain without generalized pain, and (2) incorporating progressive, low-intensity, submaximal fitness and endurance activities into the pain management and health promotion strategies for patients with chronic low back pain with generalized pain. (Grade of Recommendation A).<sup>14</sup>

### **Department of Veteran’s Affairs/Department of Defense (VA/DoD)**

The 2020 VA/DoD evidence-based clinical practice guideline for the non-surgical management of hip and knee osteoarthritis gave the following recommendations (strength of recommendation):<sup>15</sup>

- We suggest offering physical therapy as part of a comprehensive management plan for patients with osteoarthritis of the hip or knee. (Weak for)
- We suggest a self-management program, including exercise and weight loss for osteoarthritis of the hip and knee, and bracing for osteoarthritis of the knee. (Weak for)

### **Health Evidence Review Commission (HERC) Oregon**

The 2012 (updated 2014) HERC coverage guidance for lower back pain: non-pharmacological/non-invasive interventions recommended exercise therapy for pain > 4 weeks duration.<sup>16</sup>

### **Institute for Clinical Systems Improvement (ICSI)**

The 2016 ICSI evidence-based clinical practice guideline for the management and non-opioid treatment of pain gave the following recommendations:

- Work Group Recommendation: Exercise should be a component of the treatment for a patient with chronic pain.
- Work Group Recommendation: Passive modalities should be performed only as an adjunct to a concomitant active physical therapy or exercise program.
- Work Group Recommendation: Extending physical therapy beyond 8 to 12 weeks for chronic pain patients should be based on objective clinical improvement.<sup>17</sup>

### **U.S. Preventative Services Task Force (USPSTF)**

The 2012 USPSTF statement for the prevention of falls in community-dwelling older adults recommended, “exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls. This is a B recommendation.”<sup>18</sup>

## **CENTERS FOR MEDICARE & MEDICAID**

Please refer to the Centers for Medicare & Medicaid (CMS) [Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services](#), for coverage definitions of outpatient rehabilitation therapy services (physical therapy, occupational therapy, and speech-language pathology services).<sup>19</sup>

## POLICY SUMMARY

Although physical therapy (PT) is not superior to other, more invasive treatment modalities, it is efficacious for the improvement of pain, function, and mobility in patients with various musculoskeletal conditions (e.g., osteoarthritis, tendinopathy). Furthermore, it is widely accepted as a first-line, conservative treatment option for musculoskeletal disorders. Several evidence-based clinical practice guidelines also recommend the use of PT to improve pain, function, and mobility in patients with musculoskeletal disorders.

## INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

## REGULATORY STATUS

### Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

### Oregon Health Plan, Medicaid

#### *Oregon Health Authority (OHA)*

According to the Oregon Health Authority, Health Systems Division: Medical Assistance Programs - Chapter 410 Division 131, PHYSICAL AND OCCUPATIONAL THERAPY SERVICES rules, certain definitions apply.<sup>20</sup> The following are excerpts from the current statute.

Excerpts from 410-131-0040 Physical and Occupational Therapy:



- (a) "Rehabilitative Services" means health care services that help an individual re-establish, restore, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability;
- (b) "Habilitative Services" means health care services that help an individual keep, learn, or improve skills and functioning for daily living, designed to establish skills that have not yet been acquired at an age-appropriate level. Examples include therapy for a child who is not walking or talking at the expected age

(4) The Division shall enroll only the following types of providers as performing providers under the PT/OT program:

- (a) An individual licensed by the relevant state licensing authority to practice physical therapy.

Excerpts from 410-131-0080 Therapy Plan of Care and Record Requirements:

(3) The rehabilitative or habilitative therapy plan must adhere to the licensing board requirements of care and shall include:

- (a) Client's name, ICD diagnosis code, and type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;
- (b) Individualized, measurably objective functional goals;
- (c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;
- (d) Plan to address implementation of a home management program as appropriate from the initiation of therapy forward;
- (e) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and
- (f) For home health clients, any additional requirements included in OAR chapter 410 division 127.

(6) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care shall include:

- (a) The need for continuing rehabilitative or habilitative therapy clearly stated;
- (b) Changes to the rehabilitative or habilitative therapy plan of care, including changes to duration and frequency of intervention; and
- (c) Any changes or modifications to the therapy plan of care shall be documented, signed, and dated by the prescribing practitioner or therapist who developed the plan.

(7) Therapy records shall include:

- (a) A written referral, including:
  - A. The client's name;
  - B. The ICD-10-CM diagnosis code; and
  - C. Specification of the type of services, amount, and duration required.
- (b) A copy of the signed therapy plan of care shall be on file in the provider's therapy record prior to billing for services;

- (c) Documents, evaluations, re-evaluations, and progress notes to support the rehabilitative or habilitative therapy treatment plan and prescribing provider's written orders for changes in the therapy treatment plan;
- (d) Modalities used on each date of service;
- (e) Procedures performed and amount of time spent performing the procedures, documented and signed by the therapist; and
- (f) Documentation of splint fabrication and time spent fabricating the splint.

Excerpts from 410-131-0120 Limitations of Coverage and Payment:

- (1) The provision of PT/OT evaluations and therapy services require a prescribing practitioner referral, and services shall be supported by a therapy plan of care signed and dated by the prescribing practitioner as specified in 42 CFR 440.1110.
- (2) PT/OT initial evaluations and re-evaluations do not require PA and are not subject to prepayment review (PPR), but are limited to the following:
  - (a) Up to two initial evaluations in any 12-month period; and
  - (b) Up to four re-evaluation services in any 12-month period.
- (3) Reimbursement is limited to the initial evaluation when both the initial evaluation and a re-evaluation are provided on the same day.
- (4) School-sponsored therapy services are considered supplemental to other plan-covered therapy services that the student receives. School-based therapy services may not apply toward the client's maximum therapy allowances. (See OAR chapter 410, division 133 SBHS rules.)
- (5) All other occupational and physical therapy treatments are subject to PPR and require PA following 30 visits in a calendar year. See OAR 410-131-0160.
- (6) A licensed occupational or physical therapist or a licensed occupational or physical therapy assistant under the supervision of a therapist shall be in constant attendance while therapy treatments are performed:
  - (a) Rehabilitative and habilitative therapy treatments may not exceed one hour per day each for occupational and physical therapy;
  - (b) Modalities:
    - a. Are subject to PPR and require PA following 30 habilitative and 30 rehabilitative visits in a calendar year;
    - b. Up to two modalities may be authorized per day of treatment;
    - c. Need to be billed in conjunction with a therapeutic procedure code excluding procedure code S8940; and
    - d. Each individual supervised modality code may be reported only once for each client encounter.
  - (c) Massage therapy is limited to two units per day of treatment and shall be authorized only in conjunction with another therapeutic procedure or modality.

(8) The following services are not covered under this rule:

- (a) Services not medically appropriate;
- (b) Services that are not paired with a funded diagnosis on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services pursuant to OARs 410-141-0480 and OAR 410-141-0520;
- (c) Work hardening;
- (d) Back school and back education classes;
- (e) Services included in OAR 410-120-1200 (Excluded Services Limitations);
- (f) Durable medical equipment and medical supplies other than the following splint supplies:

### Washington State Legislature

According to the Washington State Legislature, RCW 48.43.016 Utilization management standards and criteria—Health carrier requirements—Definitions, certain utilization rules apply.<sup>21</sup> The following is an excerpt:

(2)(a) A health carrier or its contracted entity may not require utilization management or review of any kind including, but not limited to, prior, concurrent, or postservice authorization for an initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care for each of the following: Chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, or speech and hearing therapies.

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