Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Outpatient Rehabilitation Therapy Services, Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)

Policy Number: PG0158
Last Review: 10/01/2024

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

X Professional
X Facility - Outpatient

DESCRIPTION:

Physical Therapy (PT) is the treatment of disorders or injuries using physical methods or modalities. A PT modality is often defined as any physical agent applied to produce therapeutic changes to biologic tissues. Modalities that are generally accepted for use include exercises, thermal, cold, ultrasonic, or electric energy devices. Due to the passive nature of therapeutic modalities, they are generally used to enable the patient to take part in active aspects of therapy.

PT may be indicated for treatment of muscle weakness, limitations in the range of motion, neuromuscular conditions, musculoskeletal conditions, lymphedema and for selected training of patients in specific techniques and exercises for their own continued use at home.

Therapeutic procedures are intended as a means of effecting change using clinical skills and/or techniques and/or services whose goal is the improvement of function. PT procedures in general include therapeutic exercises and joint mobilization. These have generally been shown to be one set of effective means of treating aspects of many musculoskeletal conditions. Therapeutic intervention may be passive or active. Passive intervention is defined as motion imparted to the body by another person or outside force, such as a joint being moved without using the muscles that ordinarily control the joint. Active intervention is defined as motion imparted to the body through
voluntary participant contraction and relaxation of the controlling muscles. Passive interventions are often used during the acute phase of treatment, when the focus is on reducing pain and swelling. Active interventions are usually begun as pain and swelling subsides, when the focus is on restoring range of motion and function.

Medically necessary PT services must be restorative in nature or for the specific purposes of designing and teaching a maintenance program for the patient to conduct at home. The services must also relate to a written treatment plan and be of the level of complexity that requires the judgment, knowledge, and skills of a physical therapist (or medical doctor/doctor of osteopathy) to perform and/or directly supervise.

The amount, frequency and duration of PT services must be seen as medically appropriate for the specific treatment regimen and be performed by a physical therapist. The services must not be of a palliative nature or provided for maintenance of the patient's status.

A qualified physical therapist, for benefit coverage purposes, is a person who is licensed as a physical therapist by the state in which he or she is practicing. A physical therapy assistant (PTA) is a person who is licensed as a PTA, if applicable, by the state in which he or she is practicing. The services of a PTA must be supervised by a licensed physical therapist at a level of supervision determined by state law or regulation. The services of a PTA cannot be provided incidental to a physician/appropriately licensed other practitioner as they are not specifically qualified as licensed physical therapists.

Occupational Therapy (OT) is a form of rehabilitation therapy involving the treatment of neuromuscular and other dysfunction through the use of specific tasks or goal-directed activities to improve an individual's functional performance. This is intended to help a patient regain performance skills lost through injury or illness. Individual patient programs are designed to improve quality of life through the recovery of specific competences, maximizing independence and the prevention of specific illness or disability.

OT includes helping patients learn or relearn specific daily living skills (e.g., basic activities of daily living or ADLs) such as dressing, eating, personal hygiene, self-care, and mobility/transfers. OT also includes specific task oriented therapeutic activities designed to restore physical function of the shoulder, elbow, wrist and/or hand that has been lost as a result of illness or injury. Occupational therapy can include the design, fabrication and fitting/maintenance of orthotics and related self-help devices including the fitting/fabrication of splints for the upper extremity.

Medically necessary OT services must be restorative in nature or for the specific purposes of designing and teaching a maintenance program for the patient to conduct at home. The services must also relate to a written treatment plan and be of the level of complexity that requires the judgment, knowledge, and skills of an occupational therapist (or medical doctor/doctor of osteopathy) to perform and/or directly supervise these services. The amount, frequency and duration of occupational therapy services must be medically appropriate for the specific treatment regimen and be performed by an occupational therapist. These services must not be of a palliative nature or provided for maintenance of the patient's status.

A qualified occupational therapist, for benefit coverage purposes, is a person who is licensed as an occupational therapist by the state in which he or she is practicing. An occupational therapy assistant (OTA) is a person who is licensed as an OTA, if applicable, by the state in which he or she is practicing. The services of an OTA must be supervised by a licensed occupational therapist at a level of supervision determined by state law or regulation. The services of an OTA cannot be provided incidental to a physician/appropriately licensed other practitioner as they are not specifically qualified as licensed occupational therapists.

PT and OT services may be considered rehabilitative or habilitative:

- Rehabilitative services refer to PT and/or OT services that help an individual regain or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.
- Habilitative services refers to PT and/or OT services that help an individual keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking at the expected age.

Speech therapy (ST) services are services deemed necessary for the diagnosis and/or treatment of speech disorders, language disorders, and cognitive communication impairments that result in communication disabilities or dysphagia (swallowing disorder). Speech therapy is the medically prescribed treatment for speech, language and voice disorders due to disease, surgery, injury, congenital anomalies, speech/language delay, or previous therapeutic processes that result in communication disabilities and/or dysphagia. Speech therapy services are provided by, or under the direction of, a licensed speech-language pathologists. Speech-language pathologists (also referred to as speech therapists) assess, diagnose, help prevent and treat disorders related to fluency (flow of speech), language, speech, swallowing and voice.

Speech therapy services can be habilitative or rehabilitative. Habilitation therapy services are intended to maintain, develop, or improve skills which have not (but normally would have) developed or which are at risk of being lost because of illness, injury, loss of a body part, or congenital abnormality. Examples include therapy for a child who is not speaking at the expected age.

Rehabilitation therapy services are intended to improve, adapt, or restore functions which have been impaired or permanently lost because of illness, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

- **Outpatient Rehabilitation Therapy Services do not require a prior authorization when the coverage criteria indicated below is met. Benefit limits may apply**
- **Procedure 97010 is bundled and not eligible for separate reimbursement** -
- **Kinesio taping is non-covered**
- **Electrical stimulation (97014, 97032, G0283) for swallowing/feeding disorders is non-covered**

Elite (Medicare Advantage) Plans:

- **CPT Code 97014 - Electrical stimulation (unattended) is not a Medicare recognized code and therefore non-covered for Elite (Medicare Advantage) Plans. See/utilize HCPCS code G0283 for electrical stimulation (unattended), to 1 or more areas for indication(s) other than wound care, as part of a therapy plan of care.**

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Refer to specific contract language regarding physical, occupational therapy and/or speech therapy. Most contracts limit the duration or number of visits.

Reimbursement:

NOTE: The evaluation codes for PT (97161, 97162, & 97163) and OT (97165, 97166, & 97167) are based on patient low, moderate, or high complexity and the level of clinical decision-making. The re-evaluation codes for PT (97164) and OT (97168) are reported for an established patient's when a revised plan of care is indicated. These codes must support the documentation requirements as outlined within the CPT parenthetical.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GO - Services delivered under an outpatient occupational therapy plan of care; or,
- GP - Services delivered under an outpatient physical therapy plan of care.
- CQ - Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant. CQ modifier must be reported with the GP therapy modifier.
- CO - Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant. CO modifier must be reported with the GO therapy modifier.

The Centers for Medicare & Medicaid Services (CMS) describes certain therapy services as "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by a physician or a non-physician practitioner outside of a certified therapy plan of care.

When reporting Physical Therapy (PT), Occupational Therapy (OT) or Speech Language Pathology (ST) "always therapy" services provided under a plan of care, CMS requires the use of Modifier GP (services delivered under an outpatient physical therapy plan of care), Modifier GO (services delivered under an outpatient occupational therapy plan of care), or Modifier GN (Services delivered under an outpatient speech language pathology plan of care) to distinguish the discipline of the plan of care under which the service is delivered.

In addition, CMS requires services furnished in whole or in part by physical therapist assistants and occupational therapy assistants to be reported with Modifier CQ (outpatient physical therapy services provided in whole or in part by a physical therapist assistant) or Modifier CO (outpatient occupational therapy services provided in whole or in part by an occupational therapy assistant) on the claim line of the service alongside Modifier GP and Modifier GO.

PT, OT, and ST services must be submitted with the appropriate revenue code (042x, 043x or 044x) and appropriate CPT or HCPCS code for the services provided.

Modifier GP, Modifier GO, and Modifier GN are required to be used with the codes designated by CMS as "always therapy services".

Revenue code 042x (physical therapy) lines may only contain Modifier GP. Revenue code 043x (occupational therapy) lines may only contain Modifier GO.

Revenue code 044x (speech-language pathology) lines may only contain Modifier GN.

Only one therapy modifier is allowed per service line to designate under which therapy plan of care the service was provided.

In accordance with CMS, services furnished in whole or in part by physical therapist assistants and occupational therapy assistants are required to be reported with Modifier CQ or Modifier CO on the claim line of the service alongside Modifier GP and Modifier GO, and effective for dates of service beginning February 15, 2024, reimbursement for such services is subject to a 15% reduction.

Coverage Criteria:

Physical Therapy (PT)

Paramount covers a physical therapy evaluation as medically necessary for the assessment of a physical impairment.

Paramount covers a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when ALL the following criteria are met:

- The participating physician or licensed health care practitioner has determined that the individual's condition can improve significantly based on physical measures (e.g., active range of motion [AROM], strength, function, or subjective report of pain level) within one month of the date that therapy begins. These services must be proposed for the treatment of a specific illness or injury.
- The services must be ordered by a physician or other licensed health care practitioner and performed by a duly licensed and certified, if applicable, PT provider
- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery.
- The program is expected to result in significant measurable therapeutic improvement in the member's condition over a clearly defined period of time.
- The PT services must be provided in accordance with an ongoing, individualized written plan of care that is reviewed with and approved by the treating physician in accordance with applicable state laws and regulations. The plan of care should be of such sufficient detail and include appropriate objective and subjective data to demonstrate the medical necessity of the proposed treatment. This information should include at least the following:
  - PT evaluation
  - Short- and long-term goals that are specific, measurable, and objective
  - Reasonable estimate as to the time when these goals will be achieved
  - Specific PT techniques, treatments, or exercises to be used
  - Frequency and duration of the treatments provided must be reasonable and customary under the generally accepted standards of practice for PT

- The member must be re-evaluated at least monthly, and the results of these evaluations recorded in a standard format. The member's progress towards achieving the stated goals must be assessed and changes made, as needed, in the treatment program

Paramount does not cover physical therapy for the treatment of ANY of the following conditions because it is considered experimental, investigational, or unproven:

- constipation
- dyspareunia
- vaginismus
- vulvodynia/vulvar vestibulitis
- sexual dysfunction unrelated to musculoskeletal or orthopedic condition
- scoliosis (e.g., Schroth Method of therapy for scoliosis)

The use of Kinesio taping is unproven and not medically necessary due to insufficient clinical evidence of safety and/or efficacy in published peer-reviewed medical literature.

Occupational Therapy (OT)

Paramount covers an occupational therapy evaluation as medically necessary for the assessment of a physical impairment.

Paramount covers a prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when ALL the following criteria are met:

- The participating physician or licensed health care practitioner has determined that the individual's condition can improve significantly based on physical measures (e.g., active range of motion [AROM], strength, function, or subjective report of pain level) within one month of the date that therapy begins. These services must be proposed for the treatment of a specific illness or injury.
- The services must be ordered by a physician or other licensed health care practitioner and performed by a duly licensed and certified, if applicable, OT provider.
- The program is expected to result in significant measurable therapeutic improvement in the member's condition over a clearly defined period of time.
- The program is designed to learn or re-learn daily living skills (e.g., bathing, dressing, and eating) or compensatory techniques to improve the level of independence in the activities of daily living; or to provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury.
- The OT services must be provided in accordance with an ongoing, individualized written plan of care that is reviewed with and approved by the treating physician in accordance with applicable state laws and regulations. The plan of care should be of such sufficient detail and include appropriate objective and subjective data to demonstrate the medical necessity of the proposed treatment. This information should include at least the following:
    - OT evaluation
    - Short- and long-term goals that are specific, measurable, and objective
    - Reasonable estimate as to the time when these goals will be achieved
    - Specific OT techniques, treatments, or exercises to be used
    - Frequency and duration of the treatments provided must be reasonable and customary under the generally accepted standards of practice for OT
    - The member must be re-evaluated at least monthly, and the results of these evaluations recorded in a standard format. The member's progress towards achieving the stated goals must be assessed and changes made, as needed, in the treatment program
- For a child, the treatment plan includes active participation/involvement of a parent or guardian.

Paramount does not cover physical therapy for the treatment of ANY of the following conditions because it is considered experimental, investigational, or unproven:

- constipation
- dyspareunia

- vaginismus
- vulvodynia/vulvar vestibulitis
- sexual dysfunction unrelated to musculoskeletal or orthopedic condition
- scoliosis (e.g., Schroth Method of therapy for scoliosis)

The use of Kinesio taping is unproven and not medically necessary due to insufficient clinical evidence of safety and/or efficacy in published peer-reviewed medical literature.

MODALITIES (97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, & G0283)

CPT codes 97012, 97016, 97018, 97022, 97024, 97026, and 97028 require supervision by the qualified professional/auxiliary personnel of the patient during the intervention.

CPT codes 97032, 97033, 97034, 97035, 97036, and 97039 require direct (one-on-one) contact with the patient by the provider (constant attendance). Coverage for these codes indicates the provider is performing the modality and cannot be performing another procedure at the same time. Only the actual time of the provider's direct contact with the patient, providing services requiring the skills of a therapist, is covered for these codes.

Modalities chosen to treat the patient's symptoms/conditions should be selected based on the most effective and efficient means of achieving the patient's functional goals. Seldom should a patient require more than one (1) or two (2) modalities to the same body part during the therapy session. Use of more than two (2) modalities on each visit date is unusual and should be carefully justified in the documentation.

The use of modalities as stand-alone treatments is 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 should also include therapeutic procedures. (There are exceptions, including wound care or when patient care is focused on modalities because the acute patient is unable to endure therapeutic procedures.) Use of only passive modalities that exceeds 4 visits should be very well supported in the documentation.

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 use of multiple modalities as contributing to the patient's progress and restoration of function. For example, it would not be medically necessary to perform both thermal ultrasound and thermal diathermy on the same area, in the same visit, as both are considered deep heat modalities.

When the symptoms that required the use of certain modalities begin to subside and function improves, the medical record should reflect the discontinuation of those modalities, so as to determine the patient's ability to self-manage any residual symptoms. As the patient improves, the medical record should reflect a progression of the other procedures of the treatment program (therapeutic exercise, therapeutic activities, etc.). In all cases, the patient and/or caregiver should be taught aspects of self-management of his/her condition from the start of therapy. Based on the CPT descriptors, these modalities apply to one or more areas treated (e.g., paraffin bath used for the left and right hand is billed as one unit).

Hot or cold packs therapy (97010)

Hot or cold packs (including ice massage) applied in the absence of associated procedures or modalities or used alone to reduce discomfort are considered not to require the unique skills of a therapist. Code 97010 is bundled. It may be bundled with any therapy code. Regardless of whether code 97010 is billed alone or in conjunction with another therapy code, this code is never paid separately. If billed alone, this code will be denied.

Mechanical traction therapy (97012)

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. Documentation should support the medical necessity of continued traction treatment in the clinic for greater than 12 visits. For cervical conditions, treatment beyond one month can usually be accomplished by self-administered mechanical traction in the home. The time devoted to patient education related to the use of home traction should be billed under 97012.

Only 1 unit of CPT code 97012 is covered per date of service.

Equipment and tables utilizing roller systems are not considered true mechanical traction. Services using this type of equipment are non-covered.

Supportive documentation should include type of traction and part of the body to which it is applied, etiology of symptoms requiring treatment.

Electrical stimulation (unattended) (G0283)
Most non-wound care electrical stimulation treatment provided in therapy should be billed as G0283 as it is often provided in a supervised manner (after skilled application by the qualified professional/auxiliary personnel) without constant, direct contact required throughout the treatment.

Code G0283 is classified as a “supervised” modality, even though it is labeled as “unattended.” A supervised modality does not require direct (one-on-one) patient contact by the provider. Most electrical stimulation conducted via the application of electrodes is considered unattended electrical stimulation. Examples of unattended electrical stimulation modalities include Interferential Current (IFC), Transcutaneous Electrical Nerve Stimulation (TENS), cyclical muscle stimulation (Russian stimulation).

These modalities should be utilized with appropriate therapeutic procedures to effect continued improvement. Note: Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves and other non-neurological reasons for disuse are causing the atrophy (e.g., post-casting or splinting of a limb, and contracture due to soft tissue scarring).

If unattended electrical stimulation is used for control of pain and swelling, there should be documented objective and/or subjective improvement in swelling and/or pain within 6 visits. If no improvement is noted, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of this modality.

Documentation must clearly support the need for electrical stimulation more than 12 visits. Some patients can be trained in the use of a home TENS unit for pain control. Only 1-2 visits should be necessary to complete the training (which may be billed as 97032). Once training is completed, code G0283 should not be billed as a treatment modality in the clinic.

THERAPEUTIC PROCEDURES (97110, 97112, 97113, 97116, 97124, 97127, 97139, 97140, 97150, 97530, 97533, 97535, 97537, 97542, 97750, 97755, 97760, 97761, 97763 and 97799)
Therapeutic procedures attempt to reduce impairments and restore function through the application of clinical skills and/or services. Use of these procedures is expected to result in improvement of the limitations/deficits in a reasonable and generally predictable period of time.

Use of these procedures requires the qualified professional/auxiliary personnel to have direct (one-on-one) patient contact. Only the actual time of direct contact with the patient providing a service which requires the skills of a therapist is considered for coverage. Supervision of a previously taught exercise or exercise program,

patients performing an exercise independently without direct contact by the qualified professional/auxiliary personnel, or use of different exercise equipment without requiring the intervention/skills of the qualified professional/ auxiliary personnel are not covered. The patient may be in the facility for a longer period of time, but only the time the qualified professional/auxiliary personnel is actually providing direct, one-on-one, patient contact which requires the skills of a therapist is considered covered time for these procedures, and only those minutes of treatment should be recorded.

Under Medicare, time spent in documentation of services (medical record production) is part of the coverage of the respective CPT code; there is no separate coverage for time spent on documentation.

CPT codes 97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, 97760, 97761, and 97763 describe distinct types of therapeutic interventions. 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 these procedures may be used in a treatment plan, documentation must support the use of each procedure as it relates to a specific therapeutic goal.

Massage therapy (97124)
If massage therapy is not specifically excluded from coverage in the benefit plan, the following condition of coverage applies.

Massage therapy may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to reduce edema, improve joint motion, or relieve muscle spasm.
Massage therapy is considered a covered service ONLY when provided by a person who is recognized by Medicare as a physical therapy provider.

Massage is non-covered as an isolated treatment.

Paramount does not cover massage therapy when it is provided in the absence of other covered physical therapy, occupational therapy, or chiropractic modalities because it is considered not medically necessary.

Paramount covers massage therapy ONLY when provided as one component of a medically necessary and covered comprehensive physical therapy or chiropractic treatment plan.

Massage chairs, aqua massage tables and roller beds are not considered massage and are non-covered.

CPT code 97124 is non-covered on the same visit date as CPT code 97140 (manual therapy techniques).

Do not bill 97124 for percussion for postural drainage.

Documentation must clearly support the need for continued massage beyond 6-8 visits, including instruction, as appropriate, to the patient and caregiver for continued treatment.

Supportive Documentation Recommendations for 97124:

- Area(s) being treated
- Objective clinical findings such as measurements of range of motion, description of muscle spasms and effect on function
- Subjective findings including pain ratings, pain location, effect on function

Unlisted Codes (97039, 97139, 97799)
Procedures/services that are billed with an unlisted code must meet medical necessity guidelines appropriate to the procedure/service.

Miscellaneous Services (Non-covered), not an all-inclusive listing:

The following are non-covered as skilled therapy services (this list may not be all-inclusive):

- Iontophoresis, except as indicated for primary focal hyperhidrosis
- Low level laser treatment (LLLT)/cold laser therapy
- Dry hydrotherapy massage (e.g., aqua massage, hydromassage, or water massage)
- Massage chairs or roller beds
- Interactive metronome therapy (Brain Bright Therapy)
- Loop reflex training
- Vestibular ocular reflex training
- Continuous passive motion (CPM) device setup and adjustments
- Craniosacral therapy
- Electro-magnetic therapy, except as indicated for chronic wounds
- Constraint Induced Movement Therapy (CIMT)
- Driving assessments
- Work-hardening programs
- Pelvic Floor Dysfunction (not including incontinence)
    - Due to the lack of peer reviewed evidence concerning the effect on patient health outcomes, skilled therapy interventions (e.g., ultrasound, electrical stimulation, soft tissue mobilization, and therapeutic exercise) for the treatment of the following conditions is considered investigational and thus non-covered.
        - pelvic floor congestion
        - pelvic floor pain not of spinal origin
        - hypersensitive clitoris
        - prostatitis
        - cystourethrocele
        - enterocele
        - rectocele
        - vulvodynia
        - vulvar vestibulitis syndrome (VVS)

Speech Therapy (ST)

Under many benefit plans, coverage for outpatient speech therapy and speech therapy provided in the home is subject to the terms, conditions and limitations of the Short-Term Rehabilitative Therapy benefit as described in the applicable benefit plan's schedule of copayments. Swallowing/feeding therapy is considered a form of speech therapy.

Outpatient speech therapy is the most medically appropriate setting for these services unless the individual independently meets coverage criteria for a different level of care.

Many benefit plans have exclusion language that impacts coverage of speech therapy, including any or all of the following:

- A maximum allowable speech therapy benefits for duration of treatment or number of visits. When this is present and the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met.
- Specific coverage exclusions for rehabilitative services for learning disabilities, developmental delays, autism, mental retardation and/or for treatments which are not restorative in nature
- Specific coverage exclusions for behavioral training/treatment or services that are considered educational and/or training in nature. In benefit plans where this exclusion is present, services that are considered training such as voice therapy for conditions such as voice disorders without evidence of an anatomic abnormality, neurological condition, or injury would not be covered.
- Specific coverage exclusions for myofunctional therapy for dysfluency (e.g., stuttering, spastic dysphonia or other involuntarily acted conditions) or functional articulation disorders (e.g., tongue thrust, lisp, verbal apraxia)
- Specific coverage exclusions for maintenance or preventive care consisting of routine, long-term, or non-

medically necessary care provided to prevent recurrences or to maintain the member's current status
- Speech therapy is only covered for the restoration of speech due to impairment following acute injuries, diseases, or conditions when the speech therapy services are expected to result in significant clinical improvement within two months.

If coverage is available for speech therapy, the following conditions of coverage apply.

Evaluation
Paramount covers an evaluation by an appropriate healthcare provider as medically necessary for EITHER of the following:
- assessment of a speech/language/voice impairment
- assessment of a swallowing/feeding disorder

A comprehensive aphasia assessment (96105) is generally covered once. Monthly or regular re-evaluations conducted to determine or document progress, e.g., Western Aphasia Battery, for a patient undergoing a restorative speech language pathology program, are to be considered a part of the treatment session and would not be covered as a separate evaluation for billing purposes. For patients with severe aphasia, comprehensive assessments would not be performed routinely without documentation explaining the need.

Speech/Language/Voice Therapy
Paramount covers as medically necessary EITHER of the following:
- A prescribed course of speech therapy by an appropriate healthcare provider for the treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation, and language and pragmatic skills assessment levels.
- A prescribed course of voice therapy by an appropriate healthcare provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, paradoxical vocal cord motion) or provided after vocal cord surgery.

When ALL of the following criteria are met:
- The treatment being recommended has the support of the treating physician.
- The therapy plan is accompanied by an evaluation completed within the last 12 months by a certified speech language pathologist that includes age-appropriate standardized tests or measures that quantify the extent of language/speech impairment, performance deviation, or pragmatic skill deficits
- The therapy being ordered requires the one-to-one intervention and supervision of a speech-language pathologist.
- The therapy plan includes specific tests and measures that will be used to document significant progress on a regular basis, not to exceed three months.
- The therapy is individualized, and meaningful improvement is expected from the therapy.
- The therapy plan includes quantifiable, attainable short- and long-term treatment goals against which progress will be documented.
- For a child, the treatment plan includes active participation/involvement of a parent or guardian.
- The speech therapy is expected to result in a significant improvement in the individual's condition within a reasonable and generally predictable period of time.

In conjunction with delivering speech therapy services, the speech therapist is expected to provide training to the patient, family, and/or caregivers to facilitate their participation in and assumption of the continued improvement and maintenance program. Periodic assessment of improvement and modification of patient- or caregiver-implemented interventions may be appropriate.

Continuation of speech therapy visits is considered medical necessary when ALL of the following criteria are met:
- Speech therapy services must be provided in accordance with an ongoing, written plan of care that is reviewed with and approved by the treating physician in accordance with applicable state laws and regulations

- There is documented quantifiable improvement towards established short- and long-term treatment goals
- Functional progress is being made
- Generalization and carryover of targeted skill into natural environment is occurring
- Goals of therapy have not been met
- Individual is actively participating in treatment sessions

Swallowing/Feeding Therapy
Paramount covers swallowing/feeding therapy as medically necessary for individuals with swallowing and children with a feeding disorder when ALL of the following criteria are met:

- The swallowing or feeding disorder is the result of an underlying medical condition.
- The medical necessity of the therapy has been demonstrated by results of testing with a videofluorographic swallowing study (VFSS) or other appropriate testing in combination with an evaluation by a certified speech-language pathologist.
- The therapy plan includes quantifiable, attainable short- and long-term treatment goals against which progress will be documented.
- The therapy is individualized, and meaningful improvement is expected from the therapy.
- The treatment includes a transition from one-to-one supervision to an individual or caregiver provided maintenance level on discharge.

Not Covered
Paramount does not cover speech/language/voice therapy, or swallowing/feeding therapy in ANY of the following situations, as it is excluded from many benefit plans and considered not medically necessary when used for these purposes:

- any computer-based learning program for speech or voice training purposes
- school speech programs
- speech, voice therapy, or swallowing/feeding therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)
- maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver
- vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- therapy or treatment intended to improve or maintain general physical condition
- therapy or treatment provided to improve or enhance job, school, or recreational performance
- long-term rehabilitative services when significant therapeutic improvement is not expected (when there is therapeutic plateau)
- swallowing/feeding therapy for food aversions

Speech therapy services do not meet the definition of medial necessity for conditions such as, but not limited to:

- behavioral problems
- attention disorders
- learning disabilities
- developmental delay
- stammering or stuttering that is not related to an underlying medical condition (e.g., a congenital abnormality of the teeth, tongue, jaw, palate)
- conceptual handicap

Paramount does not cover electrical stimulation (97014, 97032, G0283) for swallowing/feeding disorders because it is considered experimental, investigational, or unproven.

Procedure codes S9128 and S9152 are non-covered.

In cases where the member receives both occupational and speech therapy, treatments should not be duplicated, and separate treatment plans and goals should be provided.

Speech Volume Modulation System (e.g., SpeechVive™) The use of a speech volume modulation system (e.g., SpeechVive) to improve vocal loudness and/or speech clarity in patients with hypophonia secondary to Parkinson's disease (PD) is considered experimental, investigational and/or unproven.

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive, and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function (for use by qualified speech therapist.)
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing (e.g., by Boston Diagnostic Aphasia examination) with interpretation and report, per hour
97010	Application of a modality to one 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 one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Application of modality to one or more areas; diathermy (e.g., microwave)
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
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
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97127	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact (New code effective 01/01/2018)
97139	Unlisted therapeutic procedure (specify)

97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
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.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and

	Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 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
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (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
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
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(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/ prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes (New code effective 01/01/2018)
97799	Unlisted physical medicine/rehabilitation service or procedure
0733T	Remote body and limb kinematic measurement-based therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days
0734T	Remote body and limb kinematic measurement-based therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month
0791T	Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)
HCPCS CODES	
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
MODIFIERS	
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care

CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant. CQ modifier must be reported with the GP therapy modifier.
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant. CO modifier with the GO therapy modifier.
96	Habilitative Services
97	Rehabilitative Services

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 05/30/2008

Date	Explanation & Changes
07/12/2016	• Changed name from Massage therapy to Physical Therapy (PT) and Occupational Therapy (OT) • Added codes 97001, 97002, 97003, 97004, 97010, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97545, 97546, 97750, 97755, 97760, 97761, 97762, 97799, G0129, G0283, S8940, S8990, S9117 • Per the Medicare Tactical Team Meeting review and determination, code 97014 is non-covered for Elite per CMS guidelines • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
02/14/2017	• Effective 12/31/16 deleted codes 97001-97004 • Added effective 01/01/17 new codes 97161-97168 • Added Modifiers GO & GP • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
10/10/2017	• Code 97012 added as covered for all product lines with limit of 1 unit per date of service • Kinesio taping added as non-covered for all product lines • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
01/09/2018	• Effective 12/31/17 deleted codes 97532 & 97762 • Revised effective 01/01/18 codes 97760 & 97761 • Added effective 01/01/18 new codes 97127 & 97763 • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
05/24/2018	• Added Miscellaneous Services (Non-covered) per CMS guidelines that includes Interactive metronome therapy (Brain Bright Therapy) • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
09/25/2018	• Verbiage regarding Advantage limits removed per administrative direction
10/09/2018	• Manual therapy (97140) no longer requires prior authorization for children 0-3 years of age for all product lines • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
12/15/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/09/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
12/01/2023	• Remove deleted codes 97001, 97002, 97003, 97004, 97532, 97762 • Added non-covered CPT® Category III Code(s), 0733T, 0734T, 0791T • Added non-covered HCPCS code S9970 • Added Modifiers 96, 97, CQ, and CO
03/03/2024	• Medical Policy placed on the new Paramount Medical Policy format
10/01/2024	• Updated to align with Medical Mutual's Outpatient Rehabilitation Therapy Service RP-202403

	• Added additional reimbursement documentation related modifiers GP, GO, GN, CQ and CO coding requirements • Combined medical policy PG0158 Physical Therapy (PT) and Occupational Therapy (OT) with medical policy PG0285 Speech Therapy Services and changed the policy title to Outpatient Rehabilitation Therapy Services, PT, OT, ST • Removed S-codes, no longer accepted

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review