

Corporate Medical Policy

Rehabilitative Therapies

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Description of Procedure or Service

Rehabilitative Therapies are treatments of disease or injury by qualified providers that are intended to restore or move a patient toward functional capabilities present prior to the disease or injury. For treatment of congenital anomalies with significant functional impairment, rehabilitative treatments improve functional capabilities to or toward normal function for age appropriate skills. Rehabilitative Therapies include physical therapy, occupational therapy, and speech therapy when rendered by a health care professional licensed to perform these therapies.

Physical Therapy

Physical therapists are trained to perform a thorough evaluation to screen patients for medical referral; in addition physical therapists evaluate and treat neuro-musculoskeletal symptoms related to a specific illness or injury by:

- Improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility;
- Increasing ability to perform daily activities;
- Alleviating pain;
- Writing individualized exercise programs and educating both the patient and family with home instructions that promotes independence, improved quality of life and return to function.

Occupational Therapy

Occupational Therapy services evaluate and/or treat neuro-musculoskeletal and psychological symptoms related to a specific illness or injury by improving functional performance for daily activities, including feeding, dressing, bathing and other self-care activities. Occupational Therapy involves cognitive, perceptual, safety, and judgment evaluations and training. Occupational Therapy services also include the design, fabrication, and use of orthoses, guidance in the selection and use of adaptive equipment, and sensory-integrative and perceptual-motor activities.

Speech Therapy

Speech Therapy services evaluate and/or treat cognitive communication impairment and swallowing disorders related to a specific illness or injury. Speech Therapy services assist with the development and maintenance of human communication and swallowing through assessment and rehabilitation.

Hippotherapy

Hippotherapy may also be referred to as equine-assisted therapy which describes physical therapy using a horse. This treatment strategy uses equine (horse) movement to engage sensory, neuromotor, and cognitive systems to achieve functional outcomes. Hippotherapy has been proposed for patients with impaired walking or balance.

Related Policies:

Chiropractic Services

Rehabilitative Therapies

Biofeedback
TENS (Transcutaneous Electrical Nerve Stimulator)

*****Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

Policy

BCBSNC will provide coverage for Physical Therapy, Occupational Therapy, and Speech Therapy when they are determined to be medically necessary because the medical criteria and guidelines shown below have been met.

Hippotherapy is considered investigational for all applications. BCBSNC does not provide coverage for investigational services or procedures.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits for rehabilitative therapy and chiropractic services. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Benefit limits and exclusions may apply. Please check the Member's Benefit Booklet.

Swallowing/feeding therapy is considered a form of Speech Therapy and is therefore subject to the terms, conditions and limitations of the applicable benefit plan's short-term rehabilitative therapy benefit and schedule of copayments. Coverage is limited to outpatient programs unless the patient meets medical necessity criteria for inpatient admission.

Most certificates exclude cognitive rehabilitation therapy as a stand-alone therapy. Please check the Member's Benefit Booklet before applying this policy.

Effective October 1, 2019, please refer to North Carolina Session Law 2019-43 House Bill 548 for definition of the scope of practice of physical therapists.

When Rehabilitative Therapies are covered

A. General

ALL of the following criteria must be met:

1. Services are directed toward treatment of a specific disease, injury or congenital anomaly; **AND**
2. Services are expected to result in a significant and measurable improvement in functional capabilities within a reasonable and defined period of time; **AND**
3. Services are delivered by a qualified and appropriately licensed provider; **AND**
4. Services require the judgment, knowledge, and skill of a qualified provider, such as a PT, OT or speech therapist; **AND**
5. Services are considered by the Plan to be specific, effective and reasonable treatment for the patient's diagnosis and physical condition.

B. Acute inpatient rehabilitation facility

For admission and continued stay in an acute inpatient rehabilitation facility to be considered medically necessary, all the following criteria must be met:

- functional goals must be described,

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- the patient is expected to achieve these goals with inpatient rehabilitation and care that cannot be delivered in a less intensive care setting,
- the patient must require continuous rehabilitation nursing services and close supervision by a rehabilitation physician (physiatrist), and multi-disciplinary rehabilitative services.

Typically patients may be treated in a less intensive care setting when:

- their medical co-morbidities are stable,
- they require the services of less than two skilled disciplines,
- they do not require or cannot participate in three hours of active therapy per day,
- they require minimal assistance or less for mobility, transfers, and gait. The need for some minimum or contact guard assistance is not, in and of itself, a reason for continued inpatient confinement. Patients may transition to a less intensive care setting (outpatient, office or home therapy services) when they are mobile and ambulatory for household distances or they have reached lesser goals as established by their rehabilitation team.

C. Skilled Nursing Facility –reference separate policy for Skilled Nursing Facility Care

D. Acute Low Back Pain (<3 months) or an acute exacerbation of LBP:

ALL of the following criteria must be met:

1. Evaluation and screening for medical referral should occur during initial evaluation and should include the following:
 - a. Patients are screened for red flags. Red flags are associated with serious medical conditions masking as musculoskeletal pain including but not limited to tumors (patient presents with history of cancer, unexplained weight loss, night pain, pain that is not relieved with rest, etc.), cauda equine syndrome (saddle anesthesia, urine retention, fecal incontinence, etc). These patients would be referred to an appropriate provider for further evaluation and management.
 - b. Patients are screened for yellow flags. Yellow flags are believed to represent psychosocial barriers or risk for delayed recovery and may require appropriate referral. Clinicians should consider using tools like the Fear Avoidance Beliefs Questionnaire, Orebro Musculoskeletal Pain Questionnaire, or the Beck Depression Inventory to assist with identifying those patients at risk for yellow flags.
 - c. The evaluation establishes a baseline for outcome measures. Clinicians should use validated self-report outcome measures. Examples may include the Numeric Pain Scale and the Oswestry Disability Index. These tools are useful for identifying a patient's baseline status relative to pain, function and disability and for monitoring a change in the patient's status throughout the course of treatment.
 - d. Physical therapists perform evaluations and synthesize the examination data determining whether the problems to be addressed are within the scope of PT practice. Based on these judgements about diagnosis, prognosis, and patient/client goals, the PT develops a plan of care.
2. The plan of care is established based on the evaluation findings and is directed towards improving upon the impairments and functional deficits noted. This plan may include any of the following:
 - a. Manual therapy techniques such as thrust manipulation and other non-thrust mobilization techniques are considered effective in treating acute low back pain.
 - b. Utilizing specific repeated movements, exercises or procedures to promote centralization to reduce symptoms should be considered.

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- c. The use of trunk coordination, strengthening, stabilization and endurance exercises to reduce LBT and disability are considered effective for those patients presenting with trunk movement coordination impairments.
 - d. Education regarding the member's role in managing their condition, as well as appropriate activities and specifically prescribed, directed and monitored exercise should take place during treatment sessions.
 - e. Education that promotes bed rest is discouraged.
 - f. Appropriate activities, exercises, self-administered physical modalities, work place assessment/modification, and behavioral management should be considered when applicable to maximize clinical outcomes for return to function.
3. Re-Evaluation
- a. Patients whose acute low back pain symptoms do not demonstrate objective functional improvement within 6 weeks or within an appropriate timeframe for their diagnosis and co-morbidities, should be reevaluated for significant underlying causes ("red flags" or alternative diagnoses) that may contribute to persistent symptoms.
 - b. A physical therapy reevaluation is also used to document progress, update outcome measures that were established during the initial evaluation, and review the plan of care for continuation of treatment, referral to a specialist or discharge from physical therapy. Reevaluations are covered every 30 days per episode of care based on medical necessity and diagnosis.

E. Chronic Low Back Pain (> 3 months) or chronic, recurring low back pain

1. Evaluation and screening for medical referral should occur during initial evaluation and should include the following:
 - a. Patients are screened for red flags. Red flags are associated with serious medical conditions masking as musculoskeletal pain including but not limited to tumors (patient presents with history of cancer, unexplained weight loss, night pain, pain that is not relieved with rest, etc.), cauda equina syndrome (saddle anesthesia, urine retention, fecal incontinence, etc), compression fracture (history of trauma, age over 50, prolonged use of corticosteroids) etc. These patients would be referred to an appropriate provider for further evaluation and management.
 - b. Patients are screened for yellow flags. Yellow flags are believed to represent psychosocial barriers or risk for delayed recovery and may require appropriate referral. Clinicians should consider using tools like the Fear Avoidance Beliefs Questionnaire, Orebro Musculoskeletal Pain Questionnaire, or the Beck Depression Inventory to assist with identifying those patients at risk for yellow flags.
 - c. The evaluation establishes a baseline for outcome measures. Clinicians should use validated self-report outcome measures. Examples may include the Numeric Pain Scale and the Oswestry Disability Index. These tools are useful for identifying a patient's baseline status relative to pain, function and disability and for monitoring a change in the patient's status throughout the course of treatment.
2. The plan of care is established based on the evaluation findings and is directed towards improving upon the impairments and functional deficits noted. This plan may include any of the following:
 - a. Education regarding the member's role in managing their condition, as well as appropriate activities and specifically prescribed, directed and monitored exercise should take place during treatment sessions. Patient education strategies emphasize use of active pain coping strategies that decrease fear and catastrophizing; early resumption of normal or vocational activities, even when still experiencing pain; the overall favorable

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prognosis of LBP; and the importance of improvement in activity levels, not just pain relief.

- b. Education that promotes extended bed rest should be discouraged.
- c. Manual therapy is used as an adjunct to this treatment program. Thrust and non-thrust mobilization procedures should also be considered to improve mobility, reduce pain and disability in patients with sub-acute and chronic LBP and back related limb pain.
- d. Utilizing specific repeated movements, exercises or procedures to promote centralization to reduce symptoms should be considered.
- e. The use of trunk coordination, strengthening, stabilization and endurance exercises to reduce LBP and disability with movement coordination impairments and in patients who have had spine surgery.
- f. Clinicians should consider moderate to high intensity exercise for patients with chronic low back pain that is confined to the lumbo-pelvic region.
- g. Clinicians should also consider incorporating progressive, low intensity, submaximal fitness and endurance activities into pain management and health promotion strategies for patients who have both chronic low back pain and also report generalized pain in one or more joints or extremities.
- h. Appropriate activities, exercises, self-administered physical modalities, work place assessment/modification, and behavioral management should be considered.

Other diagnoses requiring Physical Therapy.

- a. Refer to general guidelines for Physical Therapy.

F. Occupational Therapy

1. All General Guidelines must be met.

G. Speech Therapy

1. All General Guidelines must be met.
2. Evaluation - up to three visits are appropriate for the evaluation, and for development and education regarding a treatment plan.
3. Speech therapy for dysphagia may be covered for actual and identifiable problems resulting from a specific disease or injury (such as a CVA, neuromuscular disease, etc.) and must be conducted pursuant to an evaluation by a qualified therapist and a specific treatment plan that incorporates techniques that have been shown to be scientifically valid. If the recommendation for therapy is based on the findings of a radiographic study (such as a modified barium swallow), the findings must be verified by a radiologist's report. The treatment plan must address the specific problem involved, the specific treatment to be administered, the specific functional goals of the therapy and the reasonable time estimate for achievement of these goals.

When Rehabilitative Therapies are not covered

A. General

1. Duplicate therapy. When a patient receives two or more therapies, the therapies should provide different treatments and not duplicate the same treatment.
2. Non-skilled services. Treatments that do not require the skills of a qualified provider, or procedures that may be carried out effectively by the patient, family, or caregivers are not covered.

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3. Services that are primarily intended for the convenience of the patient, the patient's caretaker, or the provider.
4. Maintenance programs. Drills, techniques, and exercises that preserve the patient's present level of function and prevent regression of that function are not covered. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and/or when no further functional progress is apparent or expected to occur. The maintenance program itself may be excluded as a non-covered benefit per the terms of the member's benefit booklet.
5. Acute medical facility inpatient admissions are considered not medically necessary if the hospital admission is solely for the purpose of receiving physical therapy, occupational therapy, and/or speech therapy.
6. Group therapy in physical therapy, occupational therapy, speech therapy and hippotherapy may be excluded as a non-covered benefit per the terms of the member's benefit booklet.
7. Low level laser therapy (cold laser therapy) is considered investigational for all indications, including, but not limited to: pain relief, arthritis, carpal tunnel syndrome, Raynaud's phenomenon, fibromyalgia, other musculoskeletal disorders, chronic non-healing wounds, and neurological dysfunctions.
8. Dry hydrotherapy (i.e., Aquamed, Sidmar) is considered not medically necessary.

B. Physical Therapy

1. Passive Range of motion (PROM) treatment which is not related to restoration of a specific loss of function.
2. Any of the following treatments when given alone or to a patient who presents no complications:
 - a. infrared heat
 - b. whirlpool baths
 - c. paraffin baths (except for treatment of hand impairments resulting from various arthritic conditions)
 - d. Hubbard tank/whirlpool baths (except for treatment of patients suffering burns and open wounds)
 - e. contrast baths
3. Gait motion analysis is considered investigational for rehabilitation planning and/or evaluation.
4. In general, hot and cold packs are considered integral to other modalities and procedures provided, and may be self-administered. The application of hot or cold packs when used alone is not covered, and may be excluded as a non-covered benefit per the terms of the member's benefit booklet. Therefore they are not covered separately from other modalities.
5. Acute and Chronic Low Back Pain
 - a. Passive physical modalities when used (as stand-alone treatment) are considered not medically necessary in the treatment of acute or chronic low back pain.
 - i. ultrasound
 - ii. massage, which may be excluded as a non-covered benefit per the terms of the member's benefit booklet.
 - iii. electrical stimulation when used to relieve the symptoms of low back pain
 - iv. biofeedback
 - b. TENS units may be considered on an individual basis for home use.

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6. Other Diagnoses requiring Physical Therapy

- a. When the criteria listed in the section entitled "When Rehabilitative Therapies are Covered" have not been met.

C. Occupational Therapy

1. When the criteria listed above under the general criteria section has not been met.

D. Speech Therapy

1. Use or purchase of speech therapy software programs is not covered.
2. Speech therapy services are not covered for the following conditions:
 - a. psychosocial speech delay
 - b. behavioral problems
 - c. attention disorders
 - d. conceptual handicap
 - e. mental retardation
3. Oral sensorimotor therapy or myofunctional therapy is not covered for the treatment of tongue thrust, deviant or reverse swallow, or oral myofunctional disorders in children who do not have a diagnosed neuromuscular disease adversely affecting swallowing.
4. The following treatment modalities have not been shown to be effective to the requisite degree of scientific validity and are considered investigational for treatment of dysphagia:
 - a. Deep Pharyngeal Neuromuscular Therapy (DPNS)
 - b. Vita-Stim and similar non-specific electrical stimulation methods
 - c. Any therapy involving digital stimulation of the mouth, tongue or pharynx in patient not having a specifically diagnosed neuromuscular disorder specifically and adversely effecting swallowing.

E. Hippotherapy is considered investigational.

Policy Guidelines

A session is defined as up to one hour of therapy (treatment and/or evaluation) on any given day. For Physical therapy, the session may include up to four PT modalities.

Some BCBSNC benefit plans may contain a unique benefit design structure. For treatment visits beyond 20, additional documentation of medical information including specific short term and long term goals, measureable objectives, a reasonable estimate of when the goals will be reached, and the frequency and duration of treatment may be required.

See Billing/Coding section for medical record documentation requirements.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcsnc.com. They are listed in the Category Search on the Medical Policy search page.

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Effective 1/1/2017 in order to support Control/Home Plans' compliance with the Federal requirement to separate visit limits for habilitative and rehabilitative services, Par/Host Plans may need to require that their providers are using the HCPCS modifier "96" when billing for habilitative services, or modifier "97" for rehabilitative services.

Applicable service codes covered only as part of the habilitative benefit when billed with 96 modifier: 92630, 92633, 97533, 97770, G0151, G0152, G0153, G0157, G0158, G0159, G0160, G0161, G0198, G0201, G0283, G0515, S9128, S9129, S9131

Applicable service codes: 92507, 92508, 92521, 92522, 92523, 92524, 92526, 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97127, 97139, 97140, 97150, 97161, 97162, 97163, 97164, 97166, 97167, 97168, 97530, 97535, 97537, 97542, 97755, 97760, 97761, 97763, 97799, 98925, 98926, 98927, 98928, 98929, S8940, S8948, S9152, 0552T

97140 services will be denied as integral or incidental to 98940-98943 services unless submitted with a -59 modifier, indicating a distinct procedural service.

PT, OT services are limited to one hour (4 units) for the combinations of codes submitted.

Medical Records may be requested when more than 15 visits per episode of acute low back pain are rendered.

When medical records are ordered for any of the rehabilitative therapies, they should document:

1. Onset of symptoms
2. Mechanism of injury (if known)
3. Functional impairment
4. Patient initiated treatments and effectiveness
5. Current and past treatments prescribed by the patient and provider
6. The patient's compliance with the treatment plan and its effectiveness in relieving signs and symptoms.
7. Specific physical therapy modalities being requested and expected measurable outcomes and points.
8. Complicating or extenuating circumstances requiring extended treatment
9. Other providers involved in the care of the patient.
10. A plan of care may also be ordered. This plan of care should include:
 - a. specific statements of long - and short-term goals;
 - b. measurable objectives;
 - c. a reasonable estimate of when the goals will be reached;
 - d. specific modalities and exercises to be used in treatment; and
 - e. the frequency and duration of treatment.
11. The plan of care should be updated as the patient's condition changes.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Nordin, Margareta, Campello, Marco. Physical Therapy, Exercises and the Modalities: When, What and Why. *Neurologic Clinics*. February 1999.17(1).75-89.

Rosomoff, Hubert, Steele Rosomoff, Renee. Low Back Pain, Evaluation and Management in the Primary Care Setting. *Medical Clinics of North America*. May 1999. 83(3).643-662.

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Consultant review - 3/2000

Agency for Health Care Policy and Research, (AHCPR), Pub. No. 96-N024, August 1996

Agency for Health Care Policy and Research, (AHCPR), Pub. No. 95-0642 R0643, August 1994

Medical Policy Advisory Group - Review - 4/2000

Consultant review by Physical Therapist - 6/2000

Specialty Matched Consultant Advisory Panel - 9/2000

Medical Policy Advisory Group - 9/2000

BCBSA Medical Policy Reference Manual - 7/16/99; 8.03.12

BCBSA Medical Policy Reference Manual, 8.03.03, 4/15/02

BCBSA Medical Policy Reference Manual, 8.03.04, 4/15/02

Specialty Matched Consultant Advisory Panel - 9/2002

Medical Policy Advisory Group - 10/2003

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.02, 12/18/02

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.04, 12/17/03

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 10/09/03

Specialty Matched Consultant Advisory Panel - 8/2004

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.56, 12/14/05

AquaMed Dry Hydrotherapy. JTL Enterprises, Inc. Accessed 9/15/08 from <http://www.aqua-med.com>

Dry Hydromassage. Princeton, MN:Sidmar Manufacturing, Inc.; Accessed 9/15/08 from <http://www.sidmar.com>

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.02, 12/9/10

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.04, 12/9/10

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Specialty Matched Consultant Advisory Panel- 3/2011

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.02, 6/9/11

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.04, 6/9/11

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BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.56, 5/12/11

Specialty Matched Consultant Advisory Panel- 9/2011

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 11/10/11

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Specialty Matched Consultant Advisory Panel- 9/2012

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 11/8/12

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Specialty Matched Consultant Advisory Panel- 9/2013

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 11/14/13

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BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.56, 11/14/13

Specialty Matched Consultant Advisory Panel- 9/2014

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 11/13/14

Specialty Matched Consultant Advisory Panel 9/2015

Medical Director review 9/2015

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.56, 2/11/16

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 3/10/2016

Specialty Matched Consultant Advisory Panel 9/2016

Medical Director review 9/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.56, 2/2017

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 3/2017

Specialty Matched Consultant Advisory Panel 9/2017

Medical Director review 9/2017

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.56, 6/2018

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Specialty Matched Consultant Advisory Panel 9/2018

Medical Director review 9/2018

Specialty Matched Consultant Advisory Panel 9/2019

Medical Director review 9/2019

General Assembly of North Carolina, House Bill 548; Modify Physical Therapy Definition 2019-2020 Session via <https://www.ncleg.gov/BillLookup/2019/H548>

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.56, 8/2019

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.12, 8/2019

Policy Implementation/Update Information

4/00 Medical Policy Advisory Group - Review

6/00 Original Policy

7/00 Codes and billing instructions added to billing section. System coding changes.

9/00 Specialty Matched Consultant Advisory Panel. Medical Policy Advisory Group review. Approve. Typographical errors corrected. Criteria clarified. No change to meaning of the criteria.

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- 1/01 Revised policy to include Hippotherapy as investigational. Typographical errors corrected.
- 7/02 "When Rehabilitative Therapies are not covered" section clarified.
- 10/02 Specialty Matched Consultant Advisory Panel review. No change to policy. System coding changes.
- 11/03 Aquatic therapy added as not covered when it is a part of group therapy. Therapy is covered under the physical therapy benefit if there is specific 1:1 patient contact. Group therapy for physical medicine and rehabilitation is not covered in the water or otherwise.
- 9/23/04 Specialty Matched Consultant Advisory Panel review with no changes to policy criteria. References added. Removed "diagnosis" in last sentence of Speech Therapy notation in Description section. Added verbiage to When Rehabilitative Therapies are covered section B. c., "Patients whose acute low back pain symptoms do not resolve within 6 weeks should be reevaluated by a physician...". Inserted "and/or" to statement in When Rehabilitative Therapies are not covered section A. 3., "Maintenance begins when the therapeutic goals for a treatment plan have been achieved and/or when no further...". Inserted "rendered by a provider" in When Rehabilitative Therapies are not covered section B. 5. a., "The following physical therapy treatments, rendered by a physician,..." and section B. 5. c., inserted "for home use" to say, "TENS units may be considered on an individual basis for home use." Statement added in description, "Chiropractic services and Cognitive Rehabilitation are addressed in separate policies." Billing/Coding section updated for consistent policy language. The following code/code ranges were removed from policy: 92510, 95831-95904, 97532, 97533, 97601, 97602, 97780, 97781, 98940-98943, 99201-99205, 99211-99215, 99361-99362, 99371- 99373, S9033, S9090, and Q0086 for coding clarifications.
- 11/7/05 The following statement added to non-covered indications for Speech Therapy: "Oral sensorimotor therapy or myofunctional therapy is not covered for the treatment of tongue thrust, deviant or reverse swallow, or oral myofunctional disorders in children who do not have a diagnosed neuromuscular disease adversely affecting swallowing." Notification given 11/17/05. Effective date 1/19/06.
- 10/2/06 In the section When Rehabilitative Therapies are Covered, added statement regarding medical necessity of admission and continued stay in acute inpatient rehabilitation facilities that reads: functional goals must be described, the patient is expected to achieve these goals with inpatient rehabilitation and care that cannot be delivered in a less intensive care setting and the patient must require continuous rehabilitation nursing services and close physiatrist supervision and multi-disciplinary rehabilitative services. Typically patients may be treated in a less intensive care setting when: their medical co-morbidities are stable, they require the services of less than two skilled disciplines, they do not require or cannot participate in three hours of active therapy per day, they require minimal assistance or less for mobility, transfers, and gait. Patients may transition to a less intensive care setting (outpatient or home therapy services) when they are mobile, ambulatory for household distances, and capable of performing activities of daily living. The need for some minimum or contract guard assistance is not, in and of itself, a reason for continued inpatient confinement. Also added the following statement: Speech therapy for dysphagia may be covered for actual and identifiable problems resulting from a specific disease or injury (such as a CVA, neuromuscular disease, etc.) and must be conducted pursuant to an evaluation by a qualified therapist and a specific treatment plan that incorporates techniques that have been shown to be scientifically valid. If the recommendation for therapy is based on the findings of a radiographic study (such as a modified barium swallow), the findings must be verified by a radiologist's report. The treatment plan must address the specific problem to be addressed, the specific treatment to be administered, the specific functional goals of the therapy and the reasonable time estimate for achievement of these goals. Statement added to section A of When Rehabilitative Therapies are Not Covered that reads: Low level laser therapy (cold laser therapy) is considered investigational for all indications, including, but not limited to: pain relief, arthritis, carpal tunnel syndrome, Raynaud's phenomenon,

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- fibromyalgia, other musculoskeletal disorders, chronic non-healing wounds, and neurological dysfunctions. Added item 5 regarding investigational treatment of dysphagia: Deep Pharyngeal Neuromuscular Therapy, Vita-Stim and similar non-specific electrical stimulation methods and any therapy involving digital stimulation of the mouth, tongue or pharynx in patients not having a specifically diagnosed neuromuscular disorder specifically and adversely affecting swallowing. Added the following statement to the Policy Guidelines section: Requests for more than one hour of treatment per day will be reviewed on an individual consideration basis. CPT codes updated. Specialty Matched Consultant Advisory Panel review 8/21/06.
- 4/9/07 The following statement was added to Benefits Application section: Swallowing/feeding therapy is considered a form of Speech Therapy and is therefore subject to the terms, conditions and limitations of the applicable benefit plan's short-term rehabilitative therapy benefit and schedule of copayments. Coverage is limited to outpatient programs unless the patient meets medical necessity criteria for inpatient admission. (adn)
- 08/27/07 CPT code S9152 added to Billing/Coding section. New code effective 7/1/07. (adn)
- 01/28/08 CPT code S8940 added to Billing/Coding section. (adn)
- 8/11/08 All references to developmental dysfunction or delay are deleted. Item 5.a. in the Not Covered section reworded to read: "The following treatments rendered by a physician or physical therapist are considered to be either not medically necessary, unproven, or ineffective for patients with acute low back pain..."The following statement (Item D.2. in the Not Covered section) was deleted: "Speech therapy services are not covered for dysfunctions that are self-correcting, such as language therapy for young children with natural dysfluency or developmental articulation errors that may be self-correcting." Specialty Matched Consultant Advisory Panel review 6/19/08. (adn)
- 10/20/08 The following statement was added to Item A in the When Rehabilitative Therapies are not covered section, "Dry hydrotherapy (i.e., Aquamed, Sidmar) is not covered." References updated. Notification given 10/20/08. Effective date 2/2/09. (adn)
- 6/22/10 Policy Number(s) removed (amw)
- 7/1/11 Added new 2011 HCPCS codes G9041-G9044. Added new information under policy guidelines "Some BCBSNC benefit plans may contain a unique benefit design structure. For treatment visits beyond 20, additional documentation of medical information including specific short term and long term goals, measureable objectives, a reasonable estimate of when the goals will be reached, and the frequency and duration of treatment may be required. See Billing/Coding section for medical record documentation requirements. Under "When Not Covered" section, added item #3 under General "The service is primarily intended for the convenience of the patient, the patient's caretaker, or the provider." Under "When Covered" section added D. Outpatient, **Office** or Home Therapy services: All of the following criteria must be met: Services are individualized, specific, and consistent with symptoms or confirmed diagnosis of illness or injury under treatment and there is documentation outlining quantifiable, attainable treatment goals; AND Services are expected to result in a significant and measurable improvement in functional capabilities within a reasonable and clearly defined period of time; AND Services are delivered by a qualified and appropriately licensed provider; AND Services require the judgment, knowledge, and skill of a qualified provider; AND Goals of therapy are required and must be signed by a MD/DO/NP/PA prior to the start of treatment; AND Progress toward therapy goals must be documented and goals should be re-evaluated if no quantifiable progress has been achieved within a reasonable and clearly defined period of time." Specialty Matched Consultant Advisory Panel 3/2011. Medical director review 6/2011. (lpr)
- 10/11/11 Specialty Matched Advisory Panel 9/28/2011. Under "When Not Covered" section added benefit disclaimers and under B. #3 Gait motion: added reference to Gait Analysis medical policy. Under "When Covered" section D. Outpatient, Office or Home Therapy services:

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- removed #5 “Goals of therapy are required and must be signed by a MD/DO/NP/PA prior to the start of treatment.”(lpr)
- 10/25/11 Revised statement #11 under Billing/Coding Section to remove reference to plan of care recertification requirements by physician every 30 days. Reviewed with medical director (JM). (lpr)
- 1/24/12 Deleted HCPCS codes G9041-G9044 for 2012 code update. (lpr)
- 3/30/12 Deleted the statement “Requests for more than one hour of treatment per day will be reviewed on an individual consideration basis.” under Policy Guidelines section. (lpr)
- 10/30/12 Extensive revision of description, “when covered” and “when not covered” sections as well as policy guidelines section. Specialty Matched Consultant Advisory Panel review 9/21/2012. No change to policy statement. (lpr)
- 2/26/13 Under “Benefits Application” section, added a disclaimer stating “Most certificates exclude cognitive rehabilitation therapy as a stand-alone therapy. Please check the Member’s Benefit Booklet before applying this policy.” Medical director review 2/2013. (lpr)
- 10/15/13 Specialty matched consultant advisory panel review 9/18/2013. (lpr)
- 12/10/13 Under “When Covered” section statement A.4: added PT,OT,or speech therapist. Medical director review 11/2013. (lpr)
- 12/31/13 Added CPT codes 92521, 92522, 92523, 92524 to Billing/Coding section for 2014 coding update. Deleted CPT code 92506. (lpr)
- 4/15/14 Under “When Covered” section D.Speech Therapy: deleted statement f. “stammering or stuttering, which may be excluded as a non-covered benefit per the terms of the member’s benefit booklet.” Medical director review 4/2014. (lpr)
- 10/14/14 Under Billing/Coding section: removed Speech Therapy (ST) reference from the statement “PT and OT services are limited to one hour (4 units) for the combinations of codes submitted”, for consistency with the member benefit handbook. Specialty matched consultant advisory panel review 9/2014. No change to the policy statement. (lpr) (td)
- 12/30/14 Reference added. Description section updated. No changes to the policy statement. (td)
- 10/30/15 Specialty Matched Consultant Advisory Panel review 9/30/2015. Medical Director review 9/2015. Policy intent unchanged. (td)
- 4/29/16 References updated. (td)
- 10/25/16 Updated coding section. Specialty Matched Consultant Advisory Panel review 9/30/2016. Medical Director review 9/2016. (jd)
- 12/30/16 Code section updated including applicable service codes covered only as part of the habilitative benefit when billed with SZ modifier. (jd)
- 10/13/17 References updated. Specialty Matched Consultant Advisory Panel review 9/2017. Medical Director review 9/2017. (jd)
- 12/29/17 Code section updated with current modifiers for habilitative and rehabilitative services; modifier SZ deleted; 97127, 97763 also added, replacing 97762; also added G0515 to policy, replacing 97532. Codes and modifiers effective 1/1/18. (jd)
- 10/12/18 References updated. Specialty Matched Consultant Advisory Panel review 9/2018. Medical Director review 9/2018. (jd)
- 7/1/19 Billing/Coding section, added CPT code 0552T; effective 7/1/19. (jd)
- 10/15/19 Benefit Application section revised, adding the following statement based on a recent North Carolina law effective October 1, 2019: “Please refer to North Carolina Session Law 2019-43 House Bill 548 for definition of the scope of practice of physical therapists”. No change

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to policy intent. References updated. Specialty Matched Consultant Advisory Panel review 9/2019 Medical Director review 9/2019. (jd)

12/31/19 The following codes were removed from the Billing/Coding section effective 1/1/20:
95831-95834. (jd)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.