Carelon Medical Benefits Management Rehabilitation Program (updated 8/28/2024)

Frequently Asked Questions

Contents

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Program overview and administration

What is the Rehabilitation Program? How does it benefit health plan members?

The Carelon Rehabilitation Program is here to support providers in helping their patients receive care that is appropriate, safe, and affordable. Through impactful communication and education about the program, we are poised to engage providers and their office support staff in the management of the complexities associated with physical, occupational, and speech therapy services. We have developed an approach that works with providers to promote standard of care through the consistent use of evidence-based criteria.

The health plan is implementing the program to help providers in their efforts to ensure their patients receive care that is appropriate, safe, and affordable – and delivers improved results for the provider's practice too. Asking the right questions leads to delivering the right answers at the right time to patients.

How will the program be administered?

The Rehabilitation Program will be administered by Carelon on behalf of the patient's health plan. Participating in the program is most easily managed using the Carelon provider portal available 24 hours a day, 7 days a week (except for maintenance periods).

What is the relationship between Carelon and the health plan?

The health plan has contracted with Carelon to work directly with providers to assist their efforts in patient care. Carelon helps providers manage outpatient physical, occupational, and speech therapy services.

Who is Carelon?

Carelon is a leading specialty benefits management company with more than 25 years of experience and a growing presence in the management of radiology, cardiology, genetic testing, oncology, musculoskeletal, sleep management, and additional specialty areas. Carelon's mission is to help ensure delivery of health care services are more clinically appropriate, safer, and more affordable. We promote the most appropriate use of specialty care services through the application of widely accepted clinical guidelines delivered via an innovative platform of technologies and services. Carelon's Rehabilitation clinical guidelines were developed by a clinical team led by a physiatrist and therapists.

How does Carelon work with health plans?

Carelon collaborates with health plans to help improve health care quality and manage costs for some of today's complex tests and treatments, working with physicians and therapists like you to promote patient care that's appropriate, safe, and affordable. In partnership with health plans, Carelon is fully committed to achieving their goals – and providers – to improve health outcomes and reduce costs. Carelon's powerful specialty benefits platform powers evidence-based clinical solutions that span the specialized clinical categories where a health plan has chosen to focus. Carelon's robust medical necessity review process is fully compliant with regulatory and accrediting organizations, while offering a superior experience for the health plan's providers.

About the Rehabilitation program

How does the Rehabilitation program work?

Providers contact Carelon to request a review of physical, occupational, and speech therapy services. Carelon reviews for these services in outpatient settings against evidence-based clinical guidelines to ensure care is medically necessary according to medical evidence and that service codes that do not warrant skilled care are not approved within the episode of care.

When the care requested does not meet clinical criteria, Carelon's established staff of therapists and physicians provide peer-to-peer consultation.

Carelon's program takes individual clinical details into account to titrate the number of authorized visits as opposed

to program models that approve a standard number of visits upfront. Carelon measures progress based on condition management and patient outcomes. Additional visits are approved as clinically appropriate.

Unlike models that offer a one-size-fits-all approach, the Rehabilitation program reviews based on multiple clinical factors.

Are the clinical criteria available for review?
Yes, the Clinical Guidelines are easily accessible online. View Rehabilitation Clinical Guidelines.

Tools for patient success
Engaging patients in their health is a priority for therapy practices. The Rehabilitation Program supports provider efforts to reinforce important information about the therapy services recommended. The program is designed to drive adherence to care plans, motivate preventive action, and improve appropriate use of care by patients.

About the Carelon clinical review process

How do providers participate in the Rehabilitation Program through Carelon?
The most efficient way to submit a therapy service request is to use the provider portal.

The provider portal allows users to open a new order, update an existing order, and retrieve an order summary. As an online application, provider portal is available 24/7, except for maintenance periods. The first step is to register the provider in the provider portal, if not already registered. Go to *providerportal.com* to register.

If the provider has previously registered for other services managed by Carelon (diagnostic imaging, radiation therapy), there is no need to register again.

Is registration required to access the provider portal?
Each staff member of the facility who enters therapy requests may register as a user.
Here's how to do it:

- Step one: Go to www.providerportal.com and select "Register Now" to launch the registration wizard.
- Step two: Enter user details and select user role as "Servicing Provider."
- Step three: Create username and password.
- Step four: Enter a provider identifier.
- Step five: Check for an email from Carelon. Click on the link to confirm email address.

The provider portal support team will then contact the user to finalize the registration process.

What does a provider need to register?

- Provider email address
- Providers identifier
- Provider phone and fax number

The provider portal allows providers to:

- Submit a new order request.
- Update an existing one.
- Retrieve the order summary.

Which procedures require review?

Contact Carelon to obtain pre-service review for the following non-emergency clinical services:

- Physical therapy
- Occupational therapy
- Speech therapy

Providers should utilize modifiers when submitting claims to the health plan to designate the therapy type:

- GP-Physical Therapy
- GO-Occupational Therapy
- GN-Speech Therapy

CPT Codes

See the billing codes for the procedures we review

CPT codes are divided into two categories within the Carelon Rehabilitation Program.

1) Main treatment CPT codes – These service codes follow a grouper concept within the Carelon Rehabilitation Program. If the provider enters only one main treatment CPT code into the request and that date of service is authorized, the provider may render any additional main treatment CPT codes for that authorized date of service.

2) Adjunctive CPT codes – These service codes do not follow a grouper concept within the Carelon Rehabilitation Program. These CPT codes require further review against additional guideline criteria before any determination or authorization can be rendered on the therapy request as a whole and therefore must be entered individually for the request.

Note: Procedures reviewed may vary by line of business and health plan.

What markets (Carelon call center numbers below) and provider types are included in the Rehabilitation program?

The Carelon Rehab Program allows any qualified provider, based on state practice act or state regulation who can render therapy services, the ability to obtain authorization. See the Carelon Guidelines for further definition of "qualified provider". Carelon has the appropriate staff necessary to satisfy any same state licensure requirement.

- For Anthem Medicare requests, per CMS, Chiropractors are not in-scope as ordering and servicing providers for Medicare.

- For Anthem BCBS Commercial requests in Virginia, Chiropractors are not in-scope to receive prior authorization for therapy service codes within the Carelon Rehabilitation Program.

- For BCBS of NC Healthy Blue Medicaid requests, Chiropractors and Athletic Trainers are not in-scope to receive prior authorization for therapy service codes within the Carelon Rehabilitation Program.

The need to come to Carelon for prior authorization depends upon the member's plan state of issuance.
If the member is eligible for the Carelon Rehabilitation Program based on the state of issuance of their plan, a therapy prior authorization request should be submitted. If the member cannot be found, check that the member details have been entered correctly. If the member still cannot be found, they do not require prior authorization from Carelon based on the membership file details received from the health plan. The provider may contact the health plan to verify member eligibility or contact Carelon for assistance.

See below for markets in scope for the Carelon Rehabilitation Program.

Note: As of 10/1/2023 Anthem BCBS ME commercial members do not require prior authorization through Carelon until after the initial 12 treatment visits have been rendered in new therapy episodes of care, per therapy discipline. Treatment performed at the initial evaluation date of service will not count toward the 12 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization through Carelon.

Note: As of 8/1/2024 Anthem HealthKeepers Plus VA Medicaid members do not require prior authorization through until after the initial 8 treatment visits have been rendered in new therapy episodes of care, per therapy discipline, when treated by an in-network provider. If seen by an out-of-network provider, prior authorization is required for all treatment visits within the member's episode of care, per discipline. Treatment performed at the initial evaluation date of service will count toward the 8 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization. Dates of service up to and including September 30, 2024, will be reviewed by HealthKeepers, Inc. Dates of service on or after October 1, 2024, will be reviewed by Carelon.

Healthy Blue (MO) Medicaid	855.574.6479
Anthem BCBS (WI) Medicaid	833.419.2142
Anthem BCBS (IN) Medicaid	844.767.8158
Empire BCBS Health Plus (NY) Medicaid	855.574.6481
BCBS Western (NY) Medicaid	855.574.6483
Anthem BC (CA) Med Adv	833.404.1684
Anthem BCBS (CO) Med Adv	833.342.1256
Anthem BCBS (CT) Med Adv	833.305.1811
Anthem BCBS (GA) Med Adv	833.404.1681
Anthem BCBS (IN) Med Adv	833.342.1252
Anthem BCBS (KY) Med Adv	833.404.1677
Anthem BCBS (ME) Med Adv	833.775.1954
Anthem BCBS (MO) Med Adv	833.775.1956
Anthem BCBS (NH) Med Adv	833.342.1261
Amerigroup (NM) Medicare	833.775.1962
Anthem BCBS (NY) Medicare and Fully Integrated Dual Eligible (NY)	866.745.1784
Anthem BCBS (OH) Med Adv	833.419.2143
Amerigroup (TN) Medicare	833.305.1801
Amerigroup (TX) Medicare	833.305.1809
Anthem BCBS (VA) Medicare Adv	888.240.5058
Amerigroup (WA) Medicare	833.342.1258
Anthem BCBS (WI) Medicare Adv	833.775.1959
Anthem BCBS (CT) Commercial	866.714.1107
Anthem BCBS (ME) Commercial	866.714.1107
Anthem BCBS (NH) Commercial	866.714.1107
Anthem CR (IN) Commercial	833.775.1952
Anthem CR (KY) Commercial	833.419.1357
Anthem CR (MO) Commercial	833.305.1807

Anthem CR (OH) Commercial	833.404.1678
Anthem CR (WI) Commercial	833.342.1253
Anthem BCBS (GA) Commercial	866.714.1103
Empire (NY) Commercial	877.430.2288
Anthem Commercial F/I (CO, NV)	877.291.0366
Anthem BCBS (VA) Commercial	866-789-0158
BCBS of NC Healthy Blue Medicaid	866-745-1788
Anthem HealthKeepers Plus VA Medicaid	855-574-6480

Does the program include inpatient services?

No, the program does not include inpatient services or day-rehab services. Only services requested on an outpatient basis, in an outpatient place of service setting, are applicable to this program. Please note, claims filed with any other POS than what is authorized may be subject to denial.

Rehabilitation Solution in scope outpatient places of service settings include:

- Outpatient Office – POS 11
- Outpatient Independent Clinic – POS 49
- Telehealth (when covered) – POS 02 & (POS 10 where applicable)
- Outpatient Hospital – POS 22

What information do providers need to submit a therapy request to Carelon?

The information needed to submit a therapy request to Carelon can be found on the Carelon microsite in the order request checklists resource.

How do providers and their support staff use the provider portal to submit treatment requests?

Once registered, log in to the provider portal to begin the order entry process. Providers will be guided through a series of questions regarding the patient, the requested service, and the patient's clinical condition.

The therapist and/or the facilities support staff can enter a therapy prior authorization on the Carelon portal. All users are required to register for a portal account at *providerportal.com*. Clinicians ultimately are responsible for ensuring accurate input of clinical information on the prior authorization request.

What happens if providers do not call Carelon or enter information through the provider portal?

Providers are encouraged to request prior authorization before the start of services. Retrospective authorization requests may be initiated up to two business days after the treatment start date. Failure to contact Carelon for rehabilitation prior authorization may result in claim denial.

If the provider has rendered therapy services without a prior authorization on file and it is greater than the two business days allowed for retrospective authorization, those dates of service will need to be handled post-claim submission. Letters sent post-claim will direct the provider in next steps for prior authorization (i.e., post- claim clinical appropriateness review or appeal through the health plan), when available.

If the provider is being directed to Carelon for a post-claim prior authorization request the facility can complete this process on the Carelon portal or by calling the call center. The portal will recognize a date of service greater than two-business days and ask, "Has the health plan directed you to Carelon to submit a post-claim case after the claim was processed?". The provider would answer, "yes". The provider will then be prompted to enter a claim number from the health plan denial letter. The provider will then process with the prior authorization request. If clinical documentation is requested, please ensure the clinical documentation uploaded includes the post-claim dates of service for the request.

About determinations

What plays a role in a request determination?

Carelon will first review whether the selected member is exempt from prior authorization due to age band or condition. Next, Carelon will validate provider network status based on the member's plan. Where applicable, Carelon will also review the site of care to ensure it is appropriate for the member's clinical scenario (see site of care question below). Carelon will then review for medical necessity based on the member's individual clinical details entered for the request. Finally, a courtesy benefit accumulator ping will review benefit limits for the member, where applicable.

How will providers receive a determination?

If the necessary information is provided through the provider portal, determinations are immediate in most cases. Refer to the order request checklists to view the information needed to enter a request.

If the member is returning to the facility for treatment and a determination has not been received, the facility can call Carelon and ask that the request is reviewed live. If the provider cannot hold the line while the request is reviewed, they can request a same day call back with the request's determination.

How will providers know if the request met clinical criteria and was approved?

If the information provided meets the clinical criteria an order number, the number of approved visits and authorization timeframe will be issued.

How does Carelon review the appropriateness of site-of-care?

New therapy episodes of care beginning on or after 8/1/2021 for Anthem Commercial (fully insured and ASO) members with Anthem coverage through CT, CO, GA, IN, KY, MO, NH, NV and OH will have treatment therapy requests reviewed for site of care. Services in an outpatient hospital setting (place of service designation 19 or 22) will be reviewed with this guideline.

*Note: As of 1/1/24 site of care review will take place utilizing the Carelon Guideline for Site of Care: Outpatient Rehabilitative and Habilitative Services. There will be no change to the Anthem Commercial markets where site of care review will apply.

How long is a prior authorization valid?

Unless otherwise required by state law, physical therapy, occupational therapy, and speech-language therapy valid timeframes will be based on the number of visits allocated for the service. Carelon communicates the valid timeframe in the approval notification for each case.

Can an authorization number for a medical necessity determination expire?

Carelon communicates the expiration date in the approval notification provided for each case. If the request valid timeframe has expired and the member has authorized visits remaining and requires skilled care, the provider should return to the portal to submit an additional treatment request, the valid time frame cannot be extended.

There is one exception for Anthem BCBSCO commercial therapy prior authorizations requests. Effective 1/1/21, BCBSCO commercial member therapy requests with a CO state of issuance may be extended to 180 days from the start date of service, if there are un-rendered visits remaining on the authorization. This process can be initiated by calling the Carelon call center.

Why does the portal state that the initial evaluation request cannot be completed?

This messaging means that the provider has previously submitted an initial evaluation request for the member. The provider's next request submission should be an initial request for treatment, post initial evaluation. The provider should document that an initial evaluation has taken place and document the date of the initial evaluation to

proceed in submitting a treatment request.

How often should providers update the episode of care initial evaluation date in the Carelon portal for members receiving long-term therapy services?

Within the Carelon Rehabilitation Program, requests are staged based on the initial evaluation date of service as well as the previous requests medical necessity determination. For these reasons, providers are asked to keep the initial evaluation date consistent throughout the member's episode of care when submitting prior authorization requests for additional treatment.

There is one scenario in which the initial evaluation date may change and that is typically for chronic, long term or pediatric episodes of care that extend past a calendar year of treatment. In these scenarios, there is a reasonable expectation that the initial evaluation and plan of care would be updated annually. The updated initial evaluation date should also be documented annually within the member's therapy treatment requests on the Carelon portal.

What if the therapy request indicates, "Further review is required"?

While the majority of requests within the Carelon Rehabilitation Program are approved at request submission, there are a few scenarios when a request can require additional review. The most common is a third/recurring request when clinical documentation upload is required. In this scenario, providers will receive messaging on portal indicating a need for clinical documentation. Providers should upload the specified documents.

Additional scenarios that may require additional review include.

- Indication of a provider that requires a sanction check.
- Indication a purpose of therapy that does not require the skills of a therapist or for which there is no allowable benefit.
- Indication of an adjunctive service code or codes that do not require the skills of a therapist on the request (See CPT code question for a link to the CPT codes Carelon reviews). Adjunctive codes require further review against additional guideline criteria before any determination or authorization can be rendered on the therapy request.
- Indicating a primary treatment which is not evidenced based.
- A member benefit limit has been reached, where benefit limits apply.
- Indicating no functional objective progression on the outcome tool or plan of care goals.
- No mitigating factor indicated along with a lack of functional objective progression.
- Clinical documentation is incomplete.

If the request does not approve upon submission or review is needed, the request is forwarded to an appropriate therapist (i.e., physical, occupational or speech) who uses additional clinical experience and knowledge to evaluate the request against clinical guidelines. The clinical reviewer has the authority to issue order numbers in the event it is determined that the request meets clinical criteria.

If an order number could not be issued by the clinical reviewer, a Carelon physician will review the request. The physician reviewer can approve the case based on a review of information collected or through their discussion with the provider. At any time, you may contact Carelon to discuss the request or to provide additional information.

In the event the Carelon physician reviewer cannot approve the case based on the information previously collected or on the information supplied by you during a peer-to-peer discussion, the physician reviewer will issue a denial for the request.

What should a provider do if they have not received the request determination, but the patient is scheduled to return for treatment soon?

If a provider has not received a determination on their request and the patient is returning to the facility, the provider may contact the Carelon Call Center and ask that the request be reviewed live. If the provider is unable to hold while the request is reviewed, the provider facility can request a call back once the review is completed.

How can a provider obtain prior authorization results?

When registering for a portal login, users can specify the email address where notifications should be sent. Once a determination is made on the therapy request, the provider will receive an email containing a link to the determination.

What are the most common reasons a second treatment prior authorization request receives a lower visit allocation (i.e., 2-4 visits)?

When a second treatment request received a lower than typical visit allocation, there are a few possible reasons for this outcome.

- Did the provider omit an in-scope functional outcome tool (from the microsite list) on the initial treatment request and/or omit a baseline score?
- Did the provider reference the scoring scale on the provider microsite to ensure that the functional outcome tool score indicated matched the scoring scale that Carelon utilizes?
- Did the provider indicate an in-scope functional outcome tool (from the microsite list) on the second treatment request and indicate an updated score from the member's most recent visit?
- Did the provider indicate a mitigating factor if minimal to no progression is indicated on the functional outcome tool score between the initial or second treatment request?
- Did the provider indicate a change to the plan of care if minimal to no progression is indicated on the functional outcome tool score between the initial or second treatment request?
- Did the provider indicate short-term goal achievement (full or partial) on the second treatment request?
- Has a benefit limit been reached, where benefit limits apply?
- Has the member achieved the plan of care functional goals when fewer visits may be appropriate for discharge planning and home exercise program instruction?

The provider has the option to call Carelon at any time for a peer-to-peer discussion if they feel the details of their request need to be clarified.

What are the provider's options if a request does not meet clinical criteria?

Providers can contact Carelon to discuss therapy requests at any time before a determination has been made. When there is a request for a peer-to-peer consultation, Carelon will make an effort to transfer the call immediately to an available Carelon clinical reviewer. When a clinical reviewer is not available, Carelon will offer a scheduled call back time that is convenient for the provider.

If the provider receives notice of an adverse determination, depending on the market, they may have post-determination options for further review.

- **Peer to Peer:** Providers can request a peer-to-peer conversation with a Carelon clinician at any stage in the request process. A peer-to-peer can be initiated through the Carelon call center. The provider has the option to schedule the peer-to-peer at a convenient time, if necessary.
- **Reconsideration:** Some markets allow reconsideration of the denied decision, within the market-established timeframe. Reconsiderations give the provider the opportunity to clarify existing clinical information on a therapy request that did not require clinical documentation upload. A reconsideration is initiated by calling the Carelon call center.
- **Provider Document Review (PDR):** Some markets allow provider document review of the denied decision, within the market-established timeframe. Provider document review gives the provider the opportunity to upload new clinical documentation on a therapy request that requires clinical documentation upload.

Provider document review is initiated by uploading new clinical documentation on the portal.

- **Appeal:** Providers can file an appeal of the denied decision to the health plan, information on how to file an appeal can be found in the denial letter.

*As of 4/13/2024 Carelon will allow for reconsiderations for Anthem BCBS Commercial members in VA on outpatient therapy (PT, OT, ST) requests with an adverse determination.

*As of 4/13/2024 Carelon will allow for Provider Document Review (PDR) on Anthem Commercial outpatient therapy (PT, OT, ST) requests with an adverse determination.

Our facility has noticed that some of the adjunctive codes are always denied as not medically necessary, is there a reason for this?

There are CPT service codes that may be deemed not medically necessary after doing thorough evidence review within the Carelon Rehabilitation Program. Based on evidence, these codes (refer to the Carelon Guidelines for treatments in the adjunctive guideline section) have either been deemed not medically necessary (or necessary in limited clinical scenarios) due to not being a skilled service and/or having net benefit over conventional therapies.

Is a member with a diagnosis of Autism Spectrum Disorder in scope for this program?

Anthem and Carelon worked together to make improvements to the clinical review of PT/OT/ST services when used to treat Autism Spectrum Disorder or Pervasive Developmental Delays as defined by the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For Anthem commercial fully insured members with coverage through Georgia, Indiana, Kentucky, Missouri, Ohio, Wisconsin, Connecticut, New Hampshire, New York, Maine, Colorado, Nevada, and Virginia, a prior authorization is not required for PT, OT, or ST outpatient therapy services, when there is a confirmed diagnosis of Autism Spectrum Disorder/Pervasive Development Delays. Providers may file a claim without a prior authorization number if billing with one of the following primary ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9.

Does the initial evaluation require authorization and is treatment included with the initial evaluation visit?

Anthem Commercial members **do not require** prior authorization for the therapy evaluation codes or treatment codes rendered with the initial evaluation.

Anthem Medicaid and Medicare members **do not require** prior authorization for the therapy evaluation codes performed alone but do require a prior authorization for any treatment codes rendered with the initial evaluation.

Note: As of 10/1/2023 Anthem BCBS ME commercial members do not require prior authorization through Carelon until after the initial 12 treatment visits have been rendered, for new episodes of care, per therapy discipline. Treatment performed at the initial evaluation date of service will not count toward the 12 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization through Carelon.

Note: As of 8/1/2024 Anthem HealthKeepers Plus VA Medicaid members do not require prior authorization until after the initial 8 treatment visits have been rendered in new therapy episodes of care, per therapy discipline, when treated by an in-network provider. If seen by an out-of-network provider, prior authorization is required for all treatment visits within the member's episode of care, per discipline. Treatment performed at the initial evaluation date of service will count toward the 8 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization. Dates of service up to and including September 30, 2024, will be reviewed by HealthKeepers, Inc. Dates of service on or after October 1, 2024, will be reviewed by Carelon.

Beginning August 1, 2021, Anthem Commercial requests for members with Anthem coverage through CT, CO, GA, IN, KY, MO, NH, NV and OH for outpatient therapy services provided in the hospital outpatient department or hospital outpatient setting will be considered medically necessary only in certain clinical scenarios. Therefore, providers treating/billing in POS Outpatient Hospital will be subject to site of care review on **treatment requests**. While a

prior authorization for the initial evaluation is not required for Anthem Commercial members, providers may submit an evaluation request, prior to starting the episode of care. The initial evaluation will be authorized along with any main treatment codes performed that day and the provider will receive messaging on the Carelon portal regarding the site of care review for subsequent treatment requests.

Note: As of 1/1/24 site of care review will take place utilizing the Carelon Guideline for Site of Care: Outpatient Rehabilitative and Habilitative Services. There will be no change to the Anthem Commercial markets where site of care review will apply.

When answering the question about an evaluation being conducted for this treatment episode, would it apply if another therapist in the servicing facility completed the evaluation?

Yes, it would apply to anyone in the servicing facility that completed the evaluation and had developed a plan of care that a qualified provider would follow.

How does a provider initiate an episode of care in the Carelon portal?

Providers have two options for initiating an episode of care:

1) Providers can come to the portal prior to the initial evaluation and submit and evaluation request. Answering the portal question, "has an initial evaluation been performed" as "no" would allow for a 1-visit authorization for the initial evaluation and any main treatment codes rendered with the initial evaluation. If additional skilled care is required, the provider would then return to the portal to submit an initial treatment authorization request.
2) Providers can perform the initial evaluation and main treatment codes and then come to the portal within two business days of the first date of service that requires authorization. If site of care criteria (where applicable) is not met, the health plan member services team will help the member find a convenient, approvable in-network site of service, where they can continue therapy.

    a) Note: If site of care criteria is not met, only the initial evaluation date of service can be submitted on the claim.
    b) Note: Submission of individual adjunctive CPT codes will be subject to additional medical necessity review.

What if the functional tool/milestone assessment the provider utilizes is not listed on the Carelon portal?

Providers are encouraged to document an in-scope functional outcome tool on the initial treatment request and document a baseline score utilizing the scoring scale from the microsite. On subsequent treatment requests, providers should enter the updated functional outcome tool score from the member's most recent visit.

There is an option to enter "tool not listed" and a text box allowing providers to document the name of the functional tool/milestone assessment that was utilized. A manually entered functional outcome tool will not be scored.

Note: The Rehabilitation program's clinical decision trees are based on the most common functional tools/milestone assessments utilized in the therapy industry. Providers can contact the Rehabilitation Program if there is a functional outcome and/or milestone assessment tool they would like us to review for addition to the program. Functional outcome tools are reviewed biannually.

Can providers enter more than one functional tool for a complex patient case or a patient with two body parts being treated in one episode of care?

There is an opportunity to document up to two functional tools on a request noting that the patient is being treated for more than one body part. Please refer to the microsite for a list of the functional outcome tools in-scope for the program and their scoring scales.

What if the patient has multiple diagnoses relevant to their treatment episode?

Carelon educates that if the member will be seen for both diagnoses on the same date of service, by the same therapy discipline, one prior authorization request can be submitted for both diagnoses. The expectation is that both diagnoses will have functional goals captured in the plan of care. Please enter the most primary treatment diagnosis that is the reason the patient requires skilled therapy services. Additional diagnoses can be captured in several ways.

The Carelon portal allows providers to document up to two functional outcome tools/milestone assessments for multiple diagnoses or body parts being treated. In addition, multiple diagnoses can be documented in the *conditions impacting treatment or comorbidities* section of the request. Lastly additional diagnoses should be documented within the clinical documentation upload for the request, with functional goals for each diagnosis within the plan of care.

If the initial evaluation date of service is different and the member is seen on different dates of service for two diagnoses by the same therapy discipline, two prior authorization requests may be submitted. In this scenario, when entering the requests on the Carelon portal/call center, the initial evaluation dates for the two body parts must differ. Each episode of care would be required to have a plan of care containing functional goals.

Can a patient receive treatment for more than one therapy discipline (PT, OT, and ST) at the same time?

Yes, providers can request and receive separate authorizations for each therapy discipline, if the request meets for medical necessity and they do not constitute duplicative treatment (e.g., distinct goals). Each authorization would have a separate order number and a distinct valid timeframe.

Why do providers have to attest to the fact that services will be delivered by a licensed provider of therapy services?

Carelon clinical guidelines require that services meet medical necessity criteria when they are delivered under the supervision of a licensed clinician to perform those services. They are part of a complete plan of care that includes measurable, functional, and objective goals that can reasonably be attained in a predictable period of time and require the skills of a licensed provider of therapy services.

What if the provider wants more than the number of visits determined to be clinically appropriate for the request?

The number of visits determined to be clinically appropriate for the request is based on the patient's individual clinical details documented by the provider. The Rehabilitation program model allows providers to render the approved visits and see how the patient responds to therapy. Once the initial treatment visits have been delivered, providers can re-enter the portal, report the patient's improvement and get additional treatment visits approved if clinically appropriate.

In some markets, providers can choose not to accept the visit allocation determined to be clinically appropriate for the request. The provider should call Carelon for a peer-to-peer discussion with an Carelon clinician. The additional requested visits will be reviewed for medical necessity. If necessary, a partial denial can be issued for the remaining requested visits to allow the provider and the member the opportunity to appeal through the health plan.

Information from Anthem for providers related to telehealth services

Does Anthem require a prior authorization for physical, occupational and speech therapy services?

Yes, prior authorization is required for physical, occupational and speech therapy services. Treatment codes and re-evaluation codes will require a utilization management (UM) prior authorization review through Carelon.

Does Anthem cover medically necessary telehealth (audio and video) for physical, occupational, and speech therapy for all lines of business?

Yes. Certain CPT codes would be appropriate to consider for telehealth (audio and video) for physical, occupational, and speech therapies.

- Physical therapy (PT) evaluation codes 97161, 97162, 97163 and 97164
- Occupational (OT) therapy evaluation codes 97165, 97166, 97167 and 97168
- PT/OT treatment codes 97110, 97112, 97530 and 97535
- Speech therapy (ST) evaluation codes 92521, 92522, 92523 and 92524
- Speech therapy treatment codes 92507, 92526, 92606 and 92609

PT/OT codes that require equipment and/or direct physical hands-on interaction and therefore are not appropriate via telehealth include 97010-97028, 97032-97039, 97113-97124, 97139 -97150, 97533 and 97537-97546. Limitation related to state mandates and licensure/state practice act would still apply. Benefit limitations, where applicable, would still apply. Telehealth requests are documented with place of service 02 on the prior authorization request and modifier 95 or GT on the claim.

Medicare Advantage Program (including Texas MMP members)

What do providers need to take into consideration when submitting a Medicare Advantage Carelon Rehabilitation request?

- Per CMS, Chiropractors are not in scope as ordering and servicing providers for Rehabilitation services included in this program.
- The initial evaluation code does not require authorization, but any treatment service codes will require authorization if performed at the initial evaluation. Providers have two options:
    I. Providers can come to the portal, prior to the initial evaluation and answer the question, “has an initial evaluation been performed, “no” and receive an immediate 1 visit allocation. The provider would then return to portal prior to the first subsequent treatment visit to submit a prior authorization request.
    II. Providers can perform the initial evaluation and treatment and then come to the portal within two business days of the initial evaluation to submit a request for authorization. In this example, the initial evaluation date and the start date of treatment would both be the same (the initial evaluation date).
- The following Physical Therapy and Occupational Therapy CPT codes are required to be entered individually on a request, if applicable to the treatment plan, as coverage determinations may vary:
    - 97129 - One-on-one therapeutic interventions focused on thought processing and strategies to manage activities
    - 97130 - each additional 15 minutes (list separately in addition to code for primary procedure)
    - 20560 - Needle insertion(s) without injection(s), 1 or 2 muscle(s)
    - 20561 - Needle insertion(s) without injection(s), 3 or more muscle(s)
    - 97024 - Application of heat wave therapy to 1 or more areas
    - 97026 - Application of low energy heat (infrared) to 1 or more areas
    - 97032 - Application of electrical stimulation to 1 or more areas, each 15 minutes
    - 97033 - Application of medication through skin using electrical current, each 15 minutes
    - 97035 - Application of ultrasound to 1 or more areas, each 15 minutes

- G0283 - Electrical Stimulation, to one or more areas, for other than wound care
- The basis of the Rehabilitation program clinical appropriateness review includes the appropriate National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Benefit Policy Manual Chapter 15, Section 220 and 230.

Where can I access additional information?

For more information: The Rehabilitation Solution provider website offers providers tools and information at https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/

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Next Generation Solutions

Detailed Request Checklists for Physical Therapy Services

Updated 4/08/2024

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South Tower – Suite 800 Chicago, IL 60631
www.carelon.com

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2094-0619

Getting ready to place a request

Knowing what information, you will need for each request saves time. Our physical therapy services request checklist can help you identify and collect the information you need to have available when entering a request. **We recommend that you print a copy or save it to your computer to keep it handy when you are preparing to submit a request.**

Place of Services: Physical therapy services performed in the following settings require pre-authorization from Carelon Medical Benefits Management:

- ✓ Office
- ✓ Outpatient hospital (off-campus or on-campus)
- ✓ Independent clinic
- ✓ Outpatient Telehealth

Other settings (e.g., inpatient hospital, inpatient rehabilitation facilities, school, etc.) are not managed by Carelon. Please refer to the health plan.

INFORMATION YOU WILL NEED FOR PHYSICAL THERAPY SERVICES REQUESTS

For all physical therapy services requests, you will need:

Member Details

- Member first name
- Member last name
- Member date of birth
- Member ID number

Clinical Details

- Primary ICD-10 Diagnosis Code
  - One primary ICD-10 diagnosis code per request, recommend using the primary treating diagnosis unless required by your state to use referring physician's diagnosis.
  - Confirmation whether the treatment is related to an Autism Spectrum Disorder, Pervasive Developmental Delay diagnosis, or a confirmed diagnosis of Amyotrophic Lateral Sclerosis (ALS).
- CPT Code(s) Requested
  - Refer to the Rehabilitation Program CPT Code list for the codes that require prior authorization.
  - Main grouper treatment CPT Codes can be found in white on the CPT Code list.
  - Adjunctive CPT Codes can be found in blue on the CPT Code list and must be entered individually into the request.
    - The adjunctive codes are subject to additional medical necessity review and may or may not be considered medically necessary based on clinically significant net benefit above and beyond conventional therapies and/or considered as a non-skilled service.
- Request type as some CPT service codes overlap between disciplines.
  - Physical Therapy or Occupational Therapy
- Date of initial evaluation
  - The initial evaluation date should remain consistent throughout the member's episode of care at each subsequent therapy request.
- Functional Outcome Tool(s) (patient-reported or therapist-reported) and initial or baseline score for the tool.

    - The associated score(s) should be updated for each request within an episode of care.
    - Scores may not be required for some pediatric requests.
    - Ensure consistent tool usage where applicable to the member's plan of care.
    - See list of included common tools in **Appendix A**
    - Example: Quick disabilities of arm, shoulder, hand (Quick DASH) and disability score of 50%
- Number of short and/or long-term functional goals established by the evaluating provider asked on subsequent requests.
    - Number of short and/or long-term functional goals met.
    - Objective progression on functional goals
    - ***Examples of appropriate goals:***
        - Increase knee ROM to 100 degrees to allow safe, independent toilet transfers (to be achieved in 4 weeks)
        - Patient to do 8 steps with minimum assist and one handrail (8 weeks)
        - Patient will ambulate on level surface without AFO for 50 ft without loss of balance (estimated time 12 weeks)
        - Patient will be able to lift 20# with neutral C-spine and 0/10 pain to improve ability to lift feed bags at her ranch (LTG 6 weeks)
    - ***Examples of inappropriate goals:***
        - Increase knee ROM to 100 degrees (acceptable as an additional goal but not as the required functional, time-limited goal)
        - Patient to go up/downstairs (to be achieved in 8 weeks)
        - Normalize gait.
        - Patient to lift heavy load without discomfort.
        - LEFS score of 60.
- If no goals have been met, confirmation of goals in the established plan of care with partial demonstrable progress (E.g., may be expressed as a percentage towards any goals achieved).
- Mitigating factors impeding progress
    - There is little to no demonstrable progress; however, there are acceptable mitigating factors, and a treatment plan has been revised accordingly.
- A new body part or condition is being added to the current plan of care.
- Changes to the plan of care as a result of factors limiting progress or poor objective progression on functional goals.
- Ordering (Referring) Provider Details *May be therapist based on state specific direct access laws.
    - Ordering (referring) provider first name.
    - Ordering (referring) provider last name.
    - Ordering (referring) provider TIN.
    - Ordering (referring) provider NPI.
    - If you have difficulty finding the provider, please manually enter the record or call the Carelon call center to initiate the pre-authorization request. Note manually entering a provider may cause additional sanctioning review of the record.
- Servicing Facility Details
    - Servicing facility name
    - Servicing facility TIN
    - Servicing facility NPI
- Place of service type, this should match the place of service setting your facility utilizes on claims.
    - Office, Outpatient Hospital, Independent Clinic and Telehealth
- Treating Therapist Details (Required if the servicing facility group record is not billing for the request)
    - Treating therapist TIN
    - Treating therapist NPI
    - Treating therapist first name (if known)
    - Treating therapist last name (if known)
- Primary purpose of therapy

    - (e.g., rehabilitation, habilitation, maintenance, massage, taping)
    - Please refer to Carelon clinical guidelines for specific definitions.
    - There is confirmation of functional status being maintained in cases in which the appropriate purpose of therapy is to prevent loss of function that is at risk of being lost (habilitation)
- Primary treatments utilized, some of the below treatments may not have medical necessity support if chosen as a primary treatment.
    - Elastic therapeutic taping
    - Therapeutic Magnetic Resonance (TMR)
    - Whirlpool or Hydrotherapy
    - Massage Therapy
- Confirmation of the complexity level of the initial evaluation or E&M equivalent that was completed for the request.
    - Low, moderate, high, or unknown
    - Confirmation of a complex neurological, medical, or multi-trauma condition (i.e., VA with deficits, spinal cord injury, brain injury, Guillain-Barre syndrome, extensive burns, multiple fractures, severe deconditioning, etc.).
    - Confirmation of the acuity, the expected duration of the plan of care, and the member's rehabilitation potential
- Confirmation of a surgical procedure in the last three months related to the condition for which services are being requested.
- Conditions that may impact treatment or comorbidities for the member.
    - (e.g., cognitive impairment, cancer treatment or psychiatric disorders)
    - See **APPENDIX B** for a more complete list.
- Confirmation that a complete plan of care is documented.
- Confirmation of expectation of achievable functional improvement in a reasonable timeframe
    - There is attainment of functional goals established on initial evaluation or otherwise qualitative and sustained functional progress.
        - ***Examples of functional progress:***
            - Patient able to do three 4-inch steps with step-up pattern and no assistance before fatiguing.
            - Patient able to get off toilet with minimal assistance using only one-hand push-off.
            - Patient knee flexion ROM now 60 degrees (*when documented as progress towards specific functional goal such as "Increase knee ROM to 100 degrees for safe toilet transfer." Such progress might then also reasonably be documented as "ROM 60% met" if applied to this same functional goal*)
        - ***Examples of non-functional progress:***
            - Stairs ongoing
            - Toilet transfers partially met.
            - Goal 60% met (without clear indication of what parameter 60% reflects and what functional goal it applies to)
            - Strength improved to 3/5
            - Shoulder ROM increased 20 degrees.
- Confirmation that therapy has produced clinically meaningful improvement on reassessment of one or more of the therapist-rated or patient centered outcome measures documented on initial evaluation.
    - ***Example of clinically meaningful improvement on outcome measure***
        - Statistically significant improvement in outcome tool score with improvement in at least one of the functional parameters of the outcome measure (e.g., walking parameter in the Oswestry Disability Index)
    - ***Examples of non-clinically meaningful improvement on outcome measure***

        - Improvements only in non-specific, non-functional parameters of the functional tool (e.g., pain parameter in the Oswestry Disability Index)
        - Statistically insignificant improvement in outcome tool score
- Confirmation that services are being delivered by a licensed provider of therapy services.
- Confirmation that services require the skills and training of a qualified provider of therapy services and is clearly denoted within the documentation.
    - ***Examples of skilled intervention documentation:***
        - Skilled passive ROM to shoulder needed to maintain post-op restrictions and due to high risk of dislocation.
        - Advancing strengthening exercises requires skilled monitoring of patient's HR response and activity tolerance due to CHF risk.

Referencing the above clinical details and documentation during requests may be necessary and possibly requested for upload, at the time of request submission (I.e., Initial evaluation, progress notes, last three daily notes and re-evaluation).

Additionally, for Pediatric Habilitative service requests, in addition to the above information you will need:

<u>Clinical Details</u>

- Confirmation of developmental delay or other chronic disability. The therapist's assessment and/ or treatment plan for this patient indicate a delay in development or chronic disability. *Note: A learning disability alone does not constitute chronic disability for the purpose of this request.
    - This can be obtained from a physician diagnosis or therapist evaluation using standardized assessments.
- Confirmation of level of severity
    - e.g., mild, mild to moderate, moderate, moderate to severe and severe
    - This can be obtained from a physician diagnosis or therapist evaluation using standardized assessments.
- Pediatric functional outcome tool(s) or milestone assessment (patient-reported or therapist-reported) and initial or baseline score for the tool.
    - The associated score(s) should be updated for each request within an episode of care.
    - Scores may not be required for some pediatric requests.
    - See list of included common tools in **Appendix A**
    - Example: Batelle Developmental Inventory

Referencing the above clinical details and documentation during requests may be necessary and possibly requested for upload, at the time of request submission (I.e., Initial evaluation, progress notes, last three daily notes and re-evaluation.

Appendix A – Functional Tools

Functional Tool Name & Abbreviation	Scoring Scale (if grey – no score will be required for input)
10MWT - 10-meter walk test	0 - 5 meters/sec
12 Item MS Walking Scale	0 - 100 percent
2MWT - 2 Minute walk test	0 - 500 meters/sec
6MWT - 6 Minute Walk Test	0 - 1000 meters/sec
Activities Specific Balance Confidence Scale	0 – 100 percentage
ALSFRS- R- The Amyothrophic Lateral Sclerosis Functional Rating Scale	
AM-PAC/6 clicks	6 - 24
Australian Pelvic Floor Questionnaire	0 – 40
Barthel Index Get Test	0 - 20 points
BBS - Berg Balance Scale Short Form	0 - 28 points
BBS - Berg Balance Scale Long Form	0 - 56 points
BWAT - Bates Jenson Wound Assessment Tool	13 - 65 points
Chronic Respiratory Disease Questionnaire	7 - 140 points
Cognistat	
DASH - Disabilities of Arm, Shoulder, Hand	0 - 100 percentage
Dizziness Handicap Inventory	0 - 100 points
Dynamic Gait Index	0 - 24 points
FIM - Functional Independence measure	18 - 126 points
Foot and Ankle Ability Measure	0 - 100 percentage
FOTO Ankle / Foot	0 - 100
FOTO Balance Confidence	0 - 100
FOTO Elbow / Wrist / Hand	3 - 100
FOTO General Orthopedic	0 - 100
FOTO General physical functioning	0 - 100
FOTO Hip	1 - 100
FOTO Knee	0 - 100
FOTO Low Back	0 - 100
FOTO Shoulder	3 - 100
FOTO Vestibular	0 - 100
FSS Fatigue Severity Scale	9 – 63 points
Functional Gait Assessment	0 - 30 points
G- Code Functional Reporting: G8978 Mobility, G8981 Changing Maintaining Body Position, G8984 Carrying Moving Objects, G8987 Self Care, G8990 Primary Function Limitation	0 - 100 percentage or corresponding modifier
HOOS JR -Hip Disabilities and Osteoarthritis Score Junior	0 - 24 points
ICIQ-SF -International Consultation Incontinence Questionnaire- Short Form	0 - 100 points
IKDC- International Knee Documentation Committee	0 - 100 points
JFSS – Jaw Functional Status Scale	0 – 100 percentage
Keele StaRT Back Screening Tool	0 - 9
KOOS JR - Knee Disabilities and Osteoarthritis Score Junior	0 - 28 points
LEFS - Lower extremity functional scale	0 - 80 points
Lymphedema Life Impact Scale	0 - 90

Functional Tool Name & Abbreviation	Scoring Scale (if grey – no score will be required for input)
MAM-20- Manual Ability Measure- 20 Musculoskeletal	0 - 100
MAM-20- Manual Ability Measure- 20 Neurologic	0 - 100
Mini Bestest	0 - 28 points
MMSE - Mini mental state examination	0 - 30
Modified Low back disability questionnaire	0 - 50 points
NDI - Neck Disability Index	0 - 50 points
NIH Prostatis Symptom Index	0 - 43 points
ODI - Oswestry Low Back Pain Disability Questionnaire	0 - 50 points
PENN - Total Points, satisfaction, Pain, function	0 - 100 percentage
PFDI20 - Pelvic Floor Distress Inventory Summary Score	0 - 300 points
PFDI-20 - Pelvic Floor Distress Inventory-20	0 - 300 points
PFIQ-7 - Pelvic Floor Impact Questionnaire-7	0 - 300
PSFS - Patient Specific Functional Scale	0 - 10
PSFS - Patient Specific Functional Scale (Women's health conditions)	0 - 10
Quick DASH Disabilities of Arm, Shoulder, Hand	0 - 100 percentage
RBANS- The Repeatable Battery for the Assessment of Neuropsychological Status Update	
Roland Morris Low Back Pain and Disability Scale	0 - 24
SCI - Spinal Cord Injury Independence Measure III	0 - 100 points
SF-36 Questionnaire	0 - 100 percentage
SIS16 - Stroke Impact Scale- 16	16 - 80 points
SPADI - Shoulder Pain and Disability Index	0 – 100 percentage
Tinetti Balance Assessment	0 - 28
TMJ Disability Index	0 - 50
UDI-6 - Urogenital Distress Inventory-6	0 - 18
UEFI-15 - Upper Extremity Functional Index-15	0 - 100
UEFI-20 - Upper Extremity Functional Index-20	0 - 80
UEFS - Upper extremity functional scale	0 - 80 points
VSS- Vancouver Scar Scale	
Pediatric functional tools and milestone assessments	
AMCAMP- Adolescent Measure of Confidence and Musculoskeletal Performance	
Batelle Developmental Inventory	
Bayley Scales of Infant and Toddler Development-III (ed 3) (Bayley-III)	
BEERY VMI-21 -Beery-Buktenica Developmental Test of Visual Motor Intergration-21 (BEERY VMI-21)	
BOT2 - Bruninks Oseretsky Test of Motor Proficiency Complete Form and Short Form	
CAPE/PAC - Children's Assessment of Participation and Enjoyment/Preferences for Activities of Children	
DDST-II - Denver Developmental Screening Test II	
ESDM - Early Start Denver Model	
GMFM66 and GMFM88 - - Gross Motor Function Measure	
PDMS2 - Peabody Developmental Motor Scales, Second Edition	
Pediatric Balance Scale	
PEDI - Pediatric Evaluation of Disability Inventory	

Functional Tool Name & Abbreviation	Scoring Scale (if grey – no score will be required for input)
Pedi-IKDC	
Quality of Upper Extremity Skills Test	
Sensory Profile - 2nd ed	
SPM - Sensory Processing Measure	
SPM-P - Sensory Processing Measure - Preschool	
Vineland II or Vineland III	

Appendix B – Comorbidities / Associated health conditions

Depending on the clinical scenario of the individual patient, the following comorbidities may be listed. Please be prepared with any that impact your patient therapy services.

Adults:

- Morbid obesity (BMI > 40)
- Diabetes Mellitus
- Social determinants of health (E.g., nutrition, housing, communication)
- Respiratory disorder (E.g., asthma, COPD, pulmonary fibrosis, sarcoidosis, oxygen-dependency)
- Musculoskeletal disorder (E.g., rheumatoid arthritis, contracture, fracture)
- Cognitive impairment (E.g., brain injury, intellectual disability, concussion)
- Active major medical treatment (E.g., radiation, chemotherapy, hemodialysis)
- Neurological condition (E.g., prior stroke, Parkinson's, MS)
- Medical devices (E.g., PEG tube, catheter, shunt, tracheostomy)
- Psychological disorder (E.g., bipolar, ADHD)
- Pregnancy or recently post-partum (within last 6 months)
- Non-developmental impairment (E.g., uncorrected hearing or vision loss)
- Sensory processing disorder (E.g., apraxia, hemi-sensory loss)
- Heart or lung transplant
- Coronary artery disease
- Amputation

Pediatrics:

- Morbid obesity (BMI > 40)
- Diabetes Mellitus
- Social determinants of health (E.g., nutrition, housing, communication)
- Cognitive impairment (E.g., brain injury, intellectual disability, concussion)
- Language delay
- Neurological condition (E.g., spasticity, seizures, cerebral palsy)
- Musculoskeletal disorder (E.g., juvenile idiopathic arthritis, contracture, fracture)
- Psychological disorder (E.g., bipolar, ADHD)
- Genetic disorder (E.g., Down's syndrome, Fragile X)
- Active major medical treatment (E.g., radiation, chemotherapy, hemodialysis)
- Non-developmental impairment (E.g., uncorrected hearing or vision loss)
- Sensory processing disorder
- Current medical device (E.g., PEG tube, catheter, shunt, tracheostomy)

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Approval and implementation dates for specific health plans may vary. Please consult the applicable health plan for more details.

Clinical Appropriateness Guidelines

Outpatient Rehabilitative and Habilitative Services

Appropriate Use Criteria: Physical Therapy, Occupational Therapy, and Speech Therapy

Proprietary

Table of Contents

Description and Application of the Guidelines

The Carelon Clinical Appropriateness Guidelines (hereinafter "the Carelon Clinical Appropriateness Guidelines" or the "Guidelines") are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. The Guidelines establish objective and evidence-based criteria for medical necessity determinations, where possible, that can be used in support of the following:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To address patient safety concerns
- To enhance the quality of health care
- To promote the most efficient and cost-effective use of services

The Carelon guideline development process complies with applicable accreditation and legal standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up-to-date clinical principles and best practices. Resources reviewed include widely used treatment guidelines, randomized controlled trials or prospective cohort studies, and large systematic reviews or meta-analyses. Carelon reviews all of its Guidelines at least annually.

Carelon makes its Guidelines publicly available on its website. Copies of the Guidelines are also available upon oral or written request. Additional details, such as summaries of evidence, a list of the sources of evidence, and an explanation of the rationale that supports the adoption of the Guidelines, are included in each guideline document.

Although the Guidelines are publicly available, Carelon considers the Guidelines to be important, proprietary information of Carelon, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of Carelon.

Carelon applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The Carelon Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient's condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. Applicable federal and state coverage mandates take precedence over these clinical guidelines, and in the case of reviews for Medicare Advantage Plans, the Guidelines are only applied where there are not fully established CMS criteria. If requested by a health plan, Carelon will review requests based on health plan medical policy/guidelines in lieu of the Carelon Guidelines. Pharmaceuticals, radiotracers, or medical devices used in any of the diagnostic or therapeutic interventions listed in the Guidelines must be FDA approved or conditionally approved for the intended use. However, use of an FDA approved or conditionally approved product does not constitute medical necessity or guarantee reimbursement by the respective health plan.

The Guidelines may also be used by the health plan or by Carelon for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

General Clinical Guideline

Clinical Appropriateness Framework

Critical to any finding of clinical appropriateness under the guidelines for a specific diagnostic or therapeutic intervention are the following elements:

- Prior to any intervention, it is essential that the clinician confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This includes a history and physical examination and, where applicable, a review of relevant laboratory studies, diagnostic testing, and response to prior therapeutic intervention.
- The anticipated benefit of the recommended intervention is likely to outweigh any potential harms, including from delay or decreased access to services that may result (net benefit).
- Widely used treatment guidelines and/or current clinical literature and/or standards of medical practice should support that the recommended intervention offers the greatest net benefit among competing alternatives.
- There exists a reasonable likelihood that the intervention will change management and/or lead to an improved outcome for the patient.

Providers may be required to submit clinical documentation in support of a request for services. Such documentation must a) accurately reflect the clinical situation at the time of the requested service, and b) sufficiently document the ordering provider's clinical intent.

If these elements are not established with respect to a given request, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would justify a finding of clinical appropriateness. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account to the extent permitted by law.

Simultaneous Ordering of Multiple Diagnostic or Therapeutic Interventions

Requests for multiple diagnostic or therapeutic interventions at the same time will often require a peer-to-peer conversation to understand the individual circumstances that support the medical necessity of performing all interventions simultaneously. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Additionally, either of the following may apply:

- Current literature and/or standards of medical practice support that one of the requested diagnostic or therapeutic interventions is more appropriate in the clinical situation presented; or
- One of the diagnostic or therapeutic interventions requested is more likely to improve patient outcomes based on current literature and/or standards of medical practice.

Repeat Diagnostic Intervention

In general, repeated testing of the same anatomic location for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study.

Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios:

- Repeated diagnostic testing at the same facility due to technical issues
- Repeated diagnostic testing requested at a different facility due to provider preference or quality concerns

- Repeated diagnostic testing of the same anatomic area based on persistent symptoms with no clinical change, treatment, or intervention since the previous study
- Repeated diagnostic testing of the same anatomic area by different providers for the same member over a short period of time

Repeat Therapeutic Intervention

In general, repeated therapeutic intervention in the same anatomic area is considered appropriate when the prior intervention proved effective or beneficial and the expected duration of relief has lapsed. A repeat intervention requested prior to the expected duration of relief is not appropriate unless it can be confirmed that the prior intervention was never administered. Requests for on-going services may depend on completion of previously authorized services in situations where a patient's response to authorized services is relevant to a determination of clinical appropriateness.

Rehabilitative and Habilitative Therapies

Physical Therapy

Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Specific CPT codes for services should be used when available. Nonspecific or not otherwise classified codes may be subject to additional documentation requirements and review.

Convergence therapy (i.e., vision therapy) is most specifically billed under 92065; as such, it is out of scope of this guideline.

CPT/HCPCS

0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
20560	Needle insertion(s) without injection(s), 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s), 3 or more muscle(s)
90901	Biofeedback training by any modality (when done for medically necessary indications)
90912	Biofeedback training for bowel or bladder control, initial 15 minutes
90913	Biofeedback training for bowel or bladder control, additional 15 minutes
94667	Demonstration and/or evaluation of manual maneuvers to chest wall to assist movement of lung secretions
94668	Manual maneuvers to chest wall to assist movement of lung secretions
96001	Three-dimensional, video-taped, computer-based gait analysis during walking
97010	Application of hot or cold packs to 1 or more areas
97012	Application of mechanical traction to 1 or more areas
97014	Application of electrical stimulation to 1 or more areas, unattended by therapist
97016	Application of blood vessel compression or decompression device to 1 or more areas
97018	Application of hot wax bath to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97024	Application of heat wave therapy to 1 or more areas
97026	Application of low energy heat (infrared) to 1 or more areas
97028	Application of ultraviolet light to 1 or more areas
97032	Application of electrical stimulation to 1 or more areas
97033	Application of medication through skin using electrical current, each 15 minutes
97034	Therapeutic hot and cold baths to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97036	Physical therapy treatment to 1 or more areas, Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes

97124	Therapeutic massage to 1 or more areas, each 15 minutes
97139	Unlisted therapeutic procedure (specify)
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97150	Therapeutic procedures in a group setting
97161	Evaluation of physical therapy, typically 20 minutes
97162	Evaluation of physical therapy, typically 30 minutes
97163	Evaluation of physical therapy, typically 45 minutes
97164	Re-evaluation of physical therapy, typically 20 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97533	Sensory technique to enhance processing and adaptation to environmental demands, each 15 minutes
97535	Self-care or home management training, each 15 minutes
97537	Community or work reintegration training, each 15 minutes
97542	Wheelchair management, each 15 minutes
97545	Work hardening or conditioning, first 2 hours
97546	Work hardening or conditioning
97750	Physical performance test or measurement with report, each 15 minutes
97755	Assistive technology assessment to enhance functional performance, each 15 minutes
97760	Training in use of orthotics (supports, braces, or splints) for arms, legs and/or trunk, per 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes
97763	Management and/or training in use of orthotics (supports, braces, or splints) for arms, legs, and/or trunk, per 15 minutes
G0281	Electrical stimulation, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers
G0282	Electrical stimulation, to one or more areas, for wound care
G0283	Electrical Stimulation, to one or more areas, for other than wound care
G0295	Electromagnetic therapy, one or more areas, for wound care
G0329	Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers
S8940	Therapeutic horseback riding, per session
S8948	Treatment with low level laser (phototherapy) each 15 minutes
S8950	Complex lymphedema therapy, each 15 minutes
S8990	Physical or manipulative therapy for maintenance
S9090	Vertebral axial decompression (lumbar traction), per session

Modifiers

96	Habilitative Services
97	Needle insertion(s) without injection(s), 1 or 2 muscle(s)

ICD-10 Diagnosis

Refer to the ICD-10 CM Manual

General Information

Abbreviations

- Ankle foot orthosis (AFO)
- Congestive heart failure (CHF)

- Heart rate (HR)
- Long-term goals (LTG)
- Lower Extremity Functional Scale (LEFS)
- Range of motion (ROM)

Background

Physical therapy, also known as physiotherapy, is a skilled, nonsurgical treatment involving education, active exercise as well as passive measures in order to maximize physical mobility and function, and quality of life. Physical therapy is a goal-directed and collaborative approach, most commonly employed when abilities have been impaired due to a medical condition, disease, or injury.

Details and Scope

The purpose of this guideline is to establish conceptual principles and documentation requirements for the appropriate initial and subsequent use of outpatient physical therapy services for habilitation and rehabilitation, and maintenance programs. This guideline does not provide specific clinical requirements or direction for a given episode of physical therapy. Specific types of physical therapy interventions, for instance hippotherapy or wobble board, may be subject to additional guidelines (please refer to the Adjunctive and Alternative Treatments section of this document). Requirements defined by benefit design (maximum number of physical therapy visits), state and federal regulations supersede this guideline.

For requests that meet the specific criteria set forth in the clinical guidelines, determination of the appropriate number of visits will depend on some or all of the following case details as applicable to the individual clinical circumstances:

- Functional outcome tool and/or severity of impairment
- History of pertinent surgery
- Comorbidities expected to impact treatment
- Progress toward functional goals (or mitigating factors if lack of progress)
- Existence of additional, achievable, functional goals
- Potential for progress
- Revisions to the plan of care

Requesting providers will need to provide information on such factors in order to support their request for more than an evaluation visit. A peer-to-peer conversation may be required to determine appropriateness in certain cases.

Unless specifically stated in the document, these guidelines do not express any opinion about the appropriate scope of practice for the practitioners who deliver these services and should not be put forth as having such an opinion.

Definitions

- **Acceptable mitigating factors** refers to issues which could realistically contribute to or fully account for the lack of progress/improvement that would otherwise be expected during a course of treatment. These include but are not limited to an intervening fall, injury, illness, surgery, or hospitalization, transportation difficulties, or poor response to the initial treatment plan.
- **Caregiver** refers to someone who regularly looks after or helps with the care of a child or adult (patient) with a disability.
- **Duplicative therapy** refers to treatments by more than one provider (same or different discipline) which are 1) rendered during an overlapping time period, 2) intended to treat the same or similar body parts

(e.g., arm and shoulder), conditions or diagnoses, and 3) have substantively similar goals (e.g., improved functional shoulder range of motion).

- **Functional progress** refers to progress that directly reflects improvement in specific functional tasks such as mobility and self-care activities.
- **Habilitation** refers to services performed to help patients develop skills and functions for daily living that have not yet been acquired at an age-appropriate level [1,2] or keep those skills and functions which are at risk of being permanently lost (not merely fluctuating) due to illness or disease without the habilitative service.
- **Maintenance program** is defined as a program provided to the patient expressly to maintain the patient's current condition or to prevent or slow further deterioration due to a disease or illness. The creation, design and instruction of the program must require the skilled knowledge or judgement of a qualified therapist. A prescribed maintenance program can generally be performed by the patient individually or with the assistance of a caregiver. The provision of such a program would be considered a skilled intervention.
- **Qualified physical therapy provider** refers to a physical therapist or physical therapy assistant or other provider type who is duly licensed or certified, respectively, by his/her state to deliver physical therapy services and who provides such services in accordance with his/her state's PT practice act. State regulations regarding appropriate providers may supersede this guideline.
- **Rehabilitation** focuses on the maximal restoration of physical and psychological function in persons with injuries, pain syndromes, and/or other physical or cognitive impairments.[3]
- **Self-limited** refers to impairments caused by a disease process or surgical intervention that are expected to resolve in the near term solely with resumption of normal activity and/or a non-supervised home exercise program.
- **Skilled services** are those services which require the judgment, knowledge, and skills of a qualified provider. A service is not considered skilled simply because a qualified provider is performing it.

Note: Illness includes a wide range of conditions. For purposes of clarity, illness includes, but is not limited to, autism spectrum disorder and developmental delay.

Clinical Indications

Initiation of physical therapy for rehabilitative or habilitative services is considered medically necessary when criteria for both A and B are met:

A. Initial Physical Therapy Evaluation

Initial physical therapy evaluation is performed by a qualified physical therapy provider documenting **ALL** of the following:

- The reason for referral, specifically a condition that causes or contributes to one or more impairments in physical function that is not self-limited
- A need for physical therapy to:
    - restore function (rehabilitation), or
    - keep, learn, or improve function that has not yet been acquired at any age-appropriate level, or if clinically indicated, prevent loss of function that is at risk of being lost (habilitation)
- A relevant case history including comorbidities expected to impact treatment, a relevant physical examination, and a review of supporting, available documentation
- Functional impairment on at least 1 relevant, validated, therapist-rated and/or patient-reported outcome measure

- Potential for clinically meaningful progress, the assessment of which must be supported by clinical details documented within the evaluation

  Note: Potential for clinically meaningful progress *will not apply for habilitation cases in which the appropriate purpose of therapy is to prevent loss of function* that is at risk of being lost (habilitation).

B. Individualized Physical Therapy Plan of Care

Individualized physical therapy plan requires the skill and training of a qualified physical therapy provider employing interventions and delivery methods that adhere to the Clinical Appropriateness Framework (outlined in the General Clinical Guideline above). There must be a reasonable expectation that the condition being treated is amenable to such intervention and that clinically meaningful, sustained improvement will be achieved.

Note: The expectation of clinically meaningful, sustained improvement *will not apply for habilitation cases in which the appropriate purpose of therapy is to prevent loss of function* that is at risk of being lost (habilitation).

This plan must include **ALL** of the following components:

- One or more goals which are:
  - Specific
  - Measurable
  - Likely to be attained in a reasonable amount of time
  - Based on clinically significant improvement in the functional impairment(s) identified on initial evaluation
  - Formulated in collaboration with the patient and/or primary caregiver

  Note: There may be additional goals which do not meet the above criteria, but at least one goal must meet these criteria in order for medical necessity to be met.

  Note: For goals for which the need for skilled services could be unclear, it is suggested that the provider clearly document the rationale for skilled intervention to achieve the goal(s).
- Recommended frequency and estimated duration of treatment needed to achieve documented goals
- Patient and/or caregiver education particularly related to the patient's individual goals
- A recommendation for evaluation/examination by a physician or otherwise appropriate provider if there is reasonable suspicion that an undiagnosed condition outside therapist's scope of practice is present or limiting current progression towards goals

  Examples of appropriate goals:

  - Increase knee ROM to 100 degs to allow safe, independent toilet transfers (to be achieved in 4 weeks)
  - Patient to do 8 steps with minimum assist and one handrail (8 weeks)
  - Patient will ambulate on level surface without AFO for 50 ft without loss of balance (estimated time 12 weeks)
  - Patient will be able to lift 20# with neutral C-spine and 0/10 pain to improve ability to lift feed bags at her ranch (LTG 6 weeks)

  Examples of inappropriate goals:

  - Increase knee ROM to 100 degrees (acceptable as an additional goal but not as the required functional, time-limited goal)
  - Patient to go up/downstairs (to be achieved in 8 weeks)
  - Normalize gait
  - Patient to lift heavy load without discomfort

- LEFS score of 60

Proceeding with physical therapy services is considered medically necessary when ALL of the following criteria (A-F) are met:

A. Require the skills and training of a qualified physical therapy provider:

- The skilled intervention(s) must be clearly denoted in the documentation

  Examples of skilled intervention documentation:

  - Skilled passive ROM to shoulder needed to maintain post-op restrictions and due to high risk of dislocation
  - Advancing strengthening exercises, requires skilled monitoring of patient's HR response and activity tolerance due to CHF risk

B. ANY of the following:

- Therapy has produced clinically meaningful improvement on reassessment of one or more of the therapist-rated or patient centered outcome measures documented on initial evaluation

  Example of clinically meaningful improvement on outcome measure:

  - Statistically significant improvement in outcome tool score with improvement in at least one of the functional parameters of the outcome measure (e.g., walking parameter in the Oswestry Disability Index)

  Examples of non-clinically meaningful improvement on outcome measure:

  - Improvements only in non-specific, non-functional parameters of the functional tool (e.g., pain parameter in the Oswestry Disability Index)
  - Statistically insignificant improvement in outcome tool score
- There is little to no demonstrable progress; however, there are acceptable mitigating factors and a treatment plan has been revised accordingly
- There is confirmation of functional status being maintained *in cases in which the appropriate purpose of therapy is to prevent loss of function that is at risk of being lost* (habilitation)
- There is attainment of functional goals established on initial evaluation or otherwise qualitative and sustained functional progress

  Examples of functional progress:

  - Patient able to do three 4-inch steps with step-up pattern and no assistance before fatiguing
  - Patient able to get off toilet with minimal assistance using only one-hand push-off
  - Patient knee flexion ROM now 60 degrees (*when documented as progress towards specific functional goal such as "Increase knee ROM to 100 degrees for safe toilet transfer." Such progress might then also reasonably be documented as "ROM 60% met" if applied to this same functional goal*)

  Examples of non-functional progress:

  - Stairs ongoing
  - Toilet transfers partially met
  - Goal 60% met (without clear indication of what parameter 60% reflects and what functional goal it applies to)
  - Strength improved to 3/5
  - Shoulder ROM increased 20 degrees

C. There is ongoing patient and/or caregiver education and/or training

D. There is at least one unmet functional or caregiver training goal that requires skilled services to achieve

> **Note**: For goals for which the need for skilled services could be unclear, it is suggested that the provider clearly document the rationale for skilled intervention to achieve the remaining goal(s).

E. There is an expectation that the remaining goal(s) will be met within a reasonable and defined period of time

F. Progress is commensurate with the duration of treatment rendered

A recommendation for evaluation/examination by a physician or otherwise appropriate provider must be made if there is poor progression toward goals due to new or persistent symptoms

Institution of a physical therapy maintenance program may be considered medically necessary in specific circumstances (refer to Definitions section)

Exclusions

The following therapies and services are considered **not medically necessary**:

- Maintenance therapies extending beyond the creation, design, and instruction of a therapy program
- Therapies for which the primary purpose is anything other than rehabilitation or habilitation of a functional impairment due to medical illness, disease, condition, or injury. This includes therapies to improve recreational sports performance or general fitness, provide massage, or athletic taping.
- Progress is not commensurate with the duration of treatment provided (e.g., range of motion improved but only a small amount relative to the length of time patient has been in treatment, and without any reasonable mitigating factor/s accounting for it).
- Therapies deemed to be duplicative (see definition above)
- Any and all non-skilled services

  Examples of rehabilitation purpose:

  - Treatment rendered in order to restore ability to do pain-free push off for jumping
  - Treatment rendered in order to restore ability to do running gait

  Examples of recreational/sports purpose:

  - Treatment rendered in order to improve endurance to allow for running a longer distance
  - Treatment rendered in order to improve muscle endurance to allow playing full 60 minutes of basketball without muscle fatigue or pain
  - Treatment rendered to achieve (or restore) ability to jump high enough to dunk a basketball

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Adjunctive & Alternative Treatments

Physical Therapy and Occupational Therapy Adjunctive Treatments

Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Specific CPT codes for services should be used when available. Nonspecific or not otherwise classified codes may be subject to additional documentation requirements and review.

CPT/HCPCS

0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
20560	Needle insertion(s) without injection(s), 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s), 3 or more muscle(s)
90901	Biofeedback training by any modality (when done for medically necessary indications)
90912	Biofeedback training for bowel or bladder control, initial 15 minutes
90913	Biofeedback training for bowel or bladder control, additional 15 minutes
92526	Treatment of swallowing and/or oral feeding function
92605	Evaluation and prescription of non-speech-generating and alternative communication device first hour
92606	Therapeutic services for use of non-speech-generating device with programming
92607	Evaluation of patient with prescription of speech-generating and alternative communication device
92608	Evaluation and prescription of speech-generating and alternative communication device
92609	Therapeutic services for use of speech-generating device with programming
92610	Evaluation of swallowing function
92611	Fluoroscopic and video recorded motion evaluation of swallowing function
92618	Evaluation and prescription of non-speech-generating and alternative communication device
94667	Demonstration and/or evaluation of manual maneuvers to chest wall to assist movement of lung secretions
94668	Manual maneuvers to chest wall to assist movement of lung secretions
96001	Three-dimensional, video-taped, computer-based gait analysis during walking
97010	Application of hot or cold packs to 1 or more areas
97012	Application of mechanical traction to 1 or more areas
97014	Application of electrical stimulation to 1 or more areas, unattended by therapist
97016	Application of blood vessel compression or decompression device to 1 or more areas
97018	Application of hot wax bath to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97024	Application of heat wave therapy to 1 or more areas
97026	Application of low energy heat (infrared) to 1 or more areas
97028	Application of ultraviolet light to 1 or more areas

97032	Application of electrical stimulation to 1 or more areas
97033	Application of medication through skin using electrical current, each 15 minutes
97034	Therapeutic hot and cold baths to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97036	Physical therapy treatment to 1 or more areas, Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97124	Therapeutic massage to 1 or more areas, each 15 minutes
97129	One-on-one therapeutic interventions focused on thought processing and strategies to manage activities
97130	each additional 15 minutes (list separately in addition to code for primary procedure)
97139	Unlisted therapeutic procedure (specify)
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97150	Therapeutic procedures in a group setting
97161	Evaluation of physical therapy, typically 20 minutes
97162	Evaluation of physical therapy, typically 30 minutes
97163	Evaluation of physical therapy, typically 45 minutes
97164	Re-evaluation of physical therapy, typically 20 minutes
97165	Evaluation of occupational therapy, typically 30 minutes
97166	Evaluation of occupational therapy, typically 45 minutes
97167	Evaluation of occupational therapy established plan of care, typically 60 minutes
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97533	Sensory technique to enhance processing and adaptation to environmental demands, each 15 minutes
97535	Self-care or home management training, each 15 minutes
97537	Community or work reintegration training, each 15 minutes
97542	Wheelchair management, each 15 minutes
97545	Work hardening or conditioning, first 2 hours
97546	Work hardening or conditioning
97750	Physical performance test or measurement with report, each 15 minutes
97755	Assistive technology assessment to enhance functional performance, each 15 minutes
97760	Training in use of orthotics (supports, braces, or splints) for arms, legs and/or trunk, per 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes
97763	Management and/or training in use of orthotics (supports, braces, or splints) for arms, legs, and/or trunk, per 15 minutes
G0281	Electrical stimulation, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers
G0282	Electrical stimulation, to one or more areas, for wound care
G0283	Electrical Stimulation, to one or more areas, for other than wound care
G0295	Electromagnetic therapy, one or more areas, for wound care
G0329	Electromagnetic therapy, to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers
S8940	Therapeutic horseback riding, per session
S8948	Treatment with low level laser (phototherapy) each 15 minutes

S8950	Complex lymphedema therapy, each 15 minutes
S8990	Physical or manipulative therapy for maintenance
S9090	Vertebral axial decompression (lumbar traction), per session

Modifiers

96	Habilitative Services
97	Needle insertion(s) without injection(s), 1 or 2 muscle(s)

ICD-10 Diagnosis

Refer to the ICD-10 CM Manual

General Information

Background

Physical therapy and occupational therapy adjunctive treatments are distinct, therapeutic interventions or methods used by therapists to aid in their treatment of patients. Adjunctive treatments are primarily but not exclusively passive measures which are mechanical, electrical, magnetic or thermal in nature. They must be used as a complement to a more comprehensive and active therapy program and may be performed by both qualified providers of occupational and physical therapy depending on the indication. Examples include diathermy, dry needling, and hippotherapy. Performance of all services is subject to state regulations including therapy practice acts and should be rendered in accordance with those.

Scope

The purpose of this guideline is to establish appropriate use criteria for specific physical therapy and occupational therapy adjunctive treatments that complement the conceptual principles and documentation requirements established by the parent physical or occupational therapy guidelines.

Clinical indications for the appropriate use of services in these guidelines are intended to be limited to those that would be within the treatment scope of practice for qualified allied health services providers specifically physical and occupational therapists. Medical indications for the appropriate use of physical and occupational therapy adjunctive treatments are out of scope of these guidelines.

Indications and criteria for the appropriate acquisition of durable medical equipment (DME) used in provision of adjunctive therapies is also out of scope.

Therapies deemed to be duplicative (see definition below) will be considered not medically necessary.

Unless specifically stated in the document, these guidelines do not express any opinion about the appropriate scope of practice for the practitioners who deliver these services and should not be put forth as having such an opinion.

Definitions

- **Diathermy** – an electromagnetic modality used to apply superficial heat to injured tissues in order to increase blood flow and reduce swelling. It is typically used to treat muscle spasms, joint stiffness, muscle and joint pain.
- **Dry needling** – a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. Dry needling is a technique used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, and diminish persistent peripheral nociceptive input, and reduce or restore impairments of body structure and function leading to improved activity and participation (source: APTA).

- **Duplicative therapy (PT/OT)** refers to treatments by more than one provider (same or different discipline) which are 1) rendered during an overlapping time period, 2) intended to treat the same or similar body parts (e.g., arm and shoulder), conditions or diagnoses (for PT), and 3) have substantively similar goals (e.g., improved functional shoulder range of motion).
- **Elastic taping** – the application of specialized adhesive tape to specific body parts to lift the skin (microscopically), commonly with the intent of increasing proprioceptive awareness/feedback, reducing swelling and inflammation, improving blood flow, or facilitating lymphatic drainage.
- **Electrical stimulation, unattended** – treatment modality whereby an electrical current is delivered to the body with the use of a stimulator device and electrodes. Unattended refers to the situation in which the provider may be present for and involved in the set-up but whose presence is not required during the administration of the treatment.
- **Fluidotherapy** – the application of superficial, dry heat by circulation of heated air through a container of small, solid particles which then flow around a submerged body part transferring heat by convection
- **Gait analysis, instrumented** – use of dynamic electromyography (EMG), biofeedback, computers, gait labs or other devices to evaluate patients' walking patterns
- **Hippotherapy** – a form of therapy that involves horseback riding under supervised and controlled circumstances, typically for children with neuromotor and/or psychologic disabilities. It is often intended to improve gross motor function, balance, muscle spasticity, and/or cognitive function.
- **Hot/Cold packs** – application of warm/hot or cold packs to a body part for the purposes of conductive treatment of superficial tissues. Heat is commonly used to increase blood flow or mobility. Cold is often used to reduce pain, inflammation and swelling.
- **Iontophoresis** – the use of an electrical gradient to deliver medicine, typically anti-inflammatory agents, into the body via the skin.
- **Lee Silverman Voice Treatment BIG®** – proprietary program of intensive physical and occupational therapy of at least one month duration involving large, full-body exercises to improve functional movement and self-care tasks of people with Parkinson's disease and other neurological conditions. It requires company-certification of providers.
- **Low level laser therapy** – the use of a laser or light to enhance tissue repair and/or reduce inflammation and pain.
- **Mechanical traction for spinal disorders** – instrumented-assisted treatment used to distract the spine and relieve axial pressure from a particular spinal region (primarily cervical and lumbar) in patients with painful spinal-related disorders (e.g., herniated discs, radiculopathy)
- **Motion analysis, instrumented** – use of dynamic electromyography (EMG), biofeedback, computers, motion labs or other devices to evaluate patients' movement patterns
- **Phonophoresis** – the use of ultrasound to deliver medicine, typically anti-inflammatory agents, into the body via the skin.
- **Sensory integration** – technique used to enhance sensory processing and promote adaptive responses to environmental demands (per APTA/Optum coding guide), such as use of weighted vests.
- **Therapeutic magnetic resonance** – the use of pulsed electromagnetic fields (PEMF) at low frequency and low intensity to reduce inflammation and arthritic pain.
- **Ultraviolet phototherapy** – application of ultraviolet light to a patient's skin, primarily for the treatment of skin disorders and wound healing
- **Vasopneumatic compression devices** – devices applied to a joint as a means of delivering cryotherapy to reduce swelling and inflammation after surgery or injury, or applied to a limb for the treatment of lymphedema
- **Whirlpool** – a warm water pool in which the water is continuously moving and into which the patient or a specific body part is submerged.

Clinical Indications

Physical therapy and occupational therapy adjunctive treatments are considered to be medically necessary when a clinically significant net benefit above and beyond conventional therapies has been determined from currently available evidence. The provision of such adjunctive treatments must also meet the Carelon Guidelines clinical criteria for the rendering of physical or occupational therapy and is limited to the clinical indications noted below, documentation of which must be in the medical record.

Sensory Integration Therapy

Sensory integration therapy is considered medically necessary for patients diagnosed with autism spectrum disorders (ASD).

Sensory integration therapy is considered **not medically necessary** in all other clinical scenarios (see Exclusions).

Additional services

Other services covered by CPT codes listed in the coding section which are not better accounted for by a more specific service or indication listed in this guideline may be considered medically necessary when **ALL** of the following criteria are met:

- The anticipated benefit of the recommended intervention outweighs any potential harms that may result such that there is a clinically significant, net benefit.
- Current literature and/or standards of rehabilitative or habilitative practice support that the recommended intervention offers the greatest net benefit among competing alternatives.

  Note: for the purposes of this criterion, "current literature" typically requires a minimum of one well-designed randomized controlled trial that demonstrates clinically significant net benefit relative to or as a supplement to the current standard of care.
- Based on the clinical evaluation, current literature, and standards of rehabilitative or habilitative practice, there exists a reasonable likelihood that the intervention will directly or indirectly lead to an improved outcome for the patient.

Exclusions

The following physical therapy and occupational therapy adjunctive treatments are considered **not medically necessary** because a clinically significant net benefit above and beyond conventional therapies could not be determined based on currently available evidence, evidence expressly demonstrated there was not a net benefit, and/or it is a nonskilled service.

- **Diathermy** is considered not medically necessary in all clinical scenarios.
- **Dry needling** is considered not medically necessary in all clinical scenarios.
- **Elastic taping** is considered not medically necessary in all clinical scenarios.
- **Electrical stimulation, unattended** is considered not medically necessary in all clinical scenarios. (nonskilled)
- **Fluidotherapy** is considered not medically necessary in all clinical scenarios
- **Gait analysis, instrumented** is considered not medically necessary in all clinical scenarios.
- **Hippotherapy** is considered not medically necessary in all clinical scenarios.
- **Hot and/or cold pack** is considered not medically necessary in all clinical scenarios. (nonskilled)
- **Iontophoresis** is considered not medically necessary in all clinical scenarios.
- **Lee Silverman Voice Treatment BIG®** is considered not medically necessary in all clinical scenarios.

- **Low level laser** is considered not medically necessary in all clinical scenarios.
- **Mechanical traction for spinal disorders** is considered not medically necessary in all clinical scenarios.
- **Motion analysis, instrumented** is considered not medically necessary in all clinical scenarios.
- **Phonophoresis** is considered not medically necessary in all clinical scenarios.
- **Sensory integration therapy** is considered not medically necessary in all other clinical scenarios (see Indications).
- **Therapeutic magnetic resonance** is considered not medically necessary in all clinical scenarios.
- **Ultraviolet phototherapy** is considered not medically necessary in all clinical scenarios.
- **Vasopneumatic compression device** is considered not medically necessary in all clinical scenarios.
- **Whirlpool** is considered not medically necessary in all clinical scenarios.

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