



# CIGNA MEDICAL COVERAGE POLICY

This Coverage Policy should NOT be used for Great-West benefit plans.

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Subject Physical Therapy

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- Electrical Stimulators
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- Work Hardening Programs

## INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2008 CIGNA

## Coverage Policy

Under many benefit plans, coverage for outpatient physical therapy programs and physical therapy provided in the home is subject to the terms, conditions and limitations of the applicable benefit plan's Short-Term Rehabilitative Therapy benefit and schedule of copayments. Under many plans, coverage of inpatient physical therapy is subject to the terms, conditions and limitations of the Other Participating Health Care Facility/Other Health Care Facility benefit as described in the applicable plan's schedule of copayments. Many benefit plans include a maximum allowable benefit for duration of treatment or number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met. In addition, some plans specifically exclude therapy for learning disabilities, developmental delays, autism, and mental retardation and/or for that which is not restorative in nature.

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

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

- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery.

- The program is expected to result in significant therapeutic improvement over a clearly defined period of time.
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

**CIGNA does not cover physical therapy for the following as it is excluded from many benefit plans and considered not medically necessary when used for these purposes:**

- for services to prevent or slow deterioration in function or prevent recurrences, as such therapy is considered not medically necessary
- for services to improve or maintain general physical condition or for long-term rehabilitative services when significant therapeutic improvement is not expected (i.e., maintenance therapy)

**CIGNA does not cover the following treatments/programs because they are considered to be nonmedical, educational or training in nature and thus are not medically necessary. In addition, these programs are specifically excluded under many benefit plans:**

- work hardening programs
- back school
- vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- group physical therapy
- services for the purpose of enhancing athletic performance or for recreation

## General Background

Physical therapy (PT) is a prescribed program of treatment generally provided to improve or restore lost or impaired physical function resulting from illness, injury, congenital defect or surgery. The physical therapist enhances rehabilitation and recovery by clarifying a patient's impairments and functional limitations and by identifying interventions, treatment goals and precautions.

PT interventions should be structured, systematic, goal-directed, individualized and restorative in nature. The PT clinical records should document the necessity for a course of PT through objective findings and subjective complaints. A PT treatment plan should include the following elements:

- planned modalities and procedures
- frequency of treatment
- attainable short- and long-term goals that can be objectively measured
- duration of treatment, with an estimated date when established goals will be achieved

There should be a reasonable expectation that the identified goals will be met. If no improvement is documented after two weeks of treatment, an alternative treatment plan should be attempted. If no significant improvement is documented after a total of four weeks, re-evaluation by the referring provider may be indicated. If measurable improvement is made, then the progress towards identified goals should be clearly documented and the treatment plan updated accordingly.

Many patients with neuromuscular, skeletal or physical motion impairment may experience improvement when following a home treatment program prescribed by their provider. Home treatment programs may include pharmacotherapy; modifications to diet and lifestyle; splinting, supporting or wrapping; and self-monitored, graded exercise therapy that does not require professional or medical supervision.

### Modalities and Procedures

The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy." (AMA, 2007) Modalities may be supervised, not requiring direct patient contact by the provider, or modalities may require constant attendance by a healthcare

professional. Examples of supervised modalities may include application of: hot or cold packs, vasopneumatic devices, whirlpool, diathermy and infrared. Modalities that require constant attendance include: ultrasound, electrical stimulation, and iontophoresis.

The AMA CPT manual defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function." (AMA, 2007) Examples of therapeutic procedures include therapeutic exercise to develop strength and endurance, range of motion and flexibility; neuromuscular re-education of movement, balance and coordination; gait training; and manual therapy techniques (e.g., manual traction).

Passive modalities are most effective during the acute phase of treatment, since they are typically directed at reducing pain and swelling. They may also be utilized during the acute phase of the exacerbation of a chronic condition. These procedures include: electrical stimulation, ultrasound, therapeutic heat, cryotherapy, passive assistive exercise, diathermy, ultrasound and massage. Passive modalities are rarely beneficial alone and are most effective when performed as part of a comprehensive treatment approach. Improvement should be seen within the first or second visit. After one or two weeks, the clinical effectiveness of passive modalities begins to decline significantly. In some rare situations, passive modalities may be indicated for up to one or two months as part of comprehensive physical therapy program. The need for passive modalities beyond two weeks should be objectively documented in the clinical record.

Active therapeutic procedures are typically started as swelling and inflammation are reduced. The need for stabilization and support is replaced by the need for increased range of motion and restoration of function. Active care elements include increasing range of motion, strengthening primary and secondary stabilizers of a given region, and increasing the endurance capability of the muscles. Care focuses on active participation of the patient in their exercise program. Gait training, muscle strengthening, and progressive resistive exercises are considered active procedures. Many active procedures may be performed independently and safely by the patient in a nonmedically supervised setting. In general, patients should progress from active procedures to a home exercise program.

Below is a list of interventions that are associated with PT. This material is for informational purposes only and is not indicative of coverage.

- activities of daily living training and functional activities: training in self-care activities
- aquatic therapy or pool therapy: exercise in a gravity-reduced, nonweight-bearing environment performed for muscle strengthening
- diathermy: local temperature elevation within the tissues believed to promote healing; produced by application of high-frequency current, usually ultrasonic or microwave current; commonly used in acute phases of trauma recovery
- gait analysis: assessment of muscle function and joint position during ambulation; includes direct visual observation, may include videotaping (at different times for objective, permanent record), temporal and stride measurements of gait pathology, direct plantar surface measurements indicating foot-floor contact, pressure measurements with strain-gauge indicating vertical, medial-lateral, and fore-aft plane reactions, optimal tracking of activity at specific anatomic landmarks
- gait training: progressive training in ambulation and stair climbing, may involve the use of an assistive device such as a cane
- hot and cold packs: the use of moist heat is intended to increase blood flow to the area, reduce pain and improve motion. Typically performed in the acute phase of an injury, the application of cold reduces blood flow to the area to reduce swelling and for pain relief.
- hydrotherapy: application of water in treatment of disease (e.g., contrast baths, whirlpool, Hubbard tank)
- infrared: involves the treatment of damaged tissues with light from a single beam of low-intensity infrared laser or light-emitting diode; the energy is perceived as heat in superficial tissues; for stimulation of circulation (local and general) and pain relief (Note: this does not refer to the Anodyne<sup>®</sup> Therapy System, which involves delivery of infrared with an array of light-emitting diodes, also referred to as monochromatic near-infrared photoenergy [MIRE] therapy. Please refer to CIGNA HealthCare's Coverage Position titled "Anodyne<sup>®</sup> Therapy")

- iontophoresis: treatment based on the principle of like-ion repulsion; delivered by continuous direct current (DC)
- isokinetic exercise: muscle contraction during which force is exerted but muscle shortening is maximal
- massage therapy: applying pressure with the hands to affect primarily the musculoskeletal, circulatory-lymphatic system and nervous system to treat discomfort or pain
- myofascial release: soft-tissue mobilization; similar to the effect achieved by massage therapy
- neuromuscular stimulation: electrical current applied to stimulate motor nerves to induce muscle contraction
- orthotic training: training with orthotics such as braces or splints
- paraffin baths: repeated immersion and withdrawal of limb into warm paraffin soak until temporarily encased; used for topical heat application to traumatized or inflamed extremities
- prosthetic training: training/re-education with prosthetic devices
- range of motion (ROM): active or passive arcs of mobility as permitted by joint's construction; should be confined to a pain-free arc, which increases as healing occurs
- therapeutic exercises: exercise to improve functional status by increasing muscle strength, improving flexibility and increasing pulmonary function
- traction: can be accomplished manually or mechanically; involves the pulling on extremities in order to relieve pain or to treat spasm
- transcutaneous nerve stimulation (TENS): a form of electric stimulation that is thought to generate neuroregulatory peripheral and central effects and modulate pain transmission
- ultrasound therapy (US): sub-audible, high-frequency vibrations that produce non-thermal physiologic effects and may be perceived as heat in superficial tissues
- ultraviolet therapy (UV): energy perceived as heat in superficial tissues; also called light therapy

### **Literature Review**

A review of the published medical literature reveals few clinical trials that address specific modalities. Few clinical trials have been undertaken to assess the effect of individual modalities in the treatment of specific conditions. The application of therapeutic modalities is generally based on empirical experience. Rehabilitation programs typically include several treatment interventions in each session, making it difficult to draw conclusions regarding the efficacy of individual interventions for a specific musculoskeletal condition.

Taylor et al. (2007) reported on a summary of systematic reviews published from 2002 to 2005 regarding the benefits of therapeutic exercise. Outcome measures included the effect of therapeutic exercise in terms of impairment, activity limitations or participation restriction. Thirty-eight studies were included and classified into these conditions: six neurology; six cardiopulmonary; six other and twenty musculoskeletal (including: spinal n=7; peripheral n=9, arthritis n=4). The review found that there is strong evidence that therapeutic exercise was effective for patients with multiple sclerosis, osteoarthritis, subacute and chronic low back pain, chronic heart failure, coronary heart disease, chronic heart failure, coronary heart disease, chronic obstructive pulmonary disease (COPD), and intermittent claudication and after lumbar disc surgery. It was noted that exercise interventions that led to improvements were diverse but one common theme was that effective exercise programs were likely to be intensive. Therapy that led to improvements in individuals with multiple sclerosis, coronary heart disease, and COPD involved participants exercising four to five times a week at a relatively high intensity. The review also indicated that programs that were more targeted and individualized exercise were more effective. This review included systematic reviews of reasonable to good quality; however, it was noted in some of the systematic reviews some of the included trials lacked quality. Additional high-quality research is needed to determine the effectiveness of therapeutic exercise in emerging areas of practice.

Pollock et al. (2007) conducted a Cochrane review to determine if there is a difference in the recovery of postural control and lower limb function in patients with stroke depending on the physiotherapy treatment approach. The review examined approaches based on neurophysiological, orthopedic or motor learning principles, or a mixture of these treatment principles. Twenty-one trials were included in the review, five of which were included in two comparisons. The comparisons included eight trials comparing a neurophysiological approach with another approach, eight comparing motor learning approach with another approach, and eight comparing a mixed approach with another approach. The results indicated that a mixed approach was significantly more effective than no treatment or placebo control for improving functional independence. It was noted in the study that there was no significant evidence that any single approach had a better outcome than

any other single approach or no treatment control. The authors concluded that “there is evidence that physiotherapy intervention, using a mix of components from different approaches, is significantly more effective than no treatment or placebo control in the recovery of functional independence following stroke. There is insufficient evidence to conclude that any one physiotherapy approach is more effective in promoting recovery of lower limb function or postural control following stroke than any other approach.” The reviewers recommended that future research should concentrate on investigating the effectiveness of clearly described individual techniques and task-specific treatments.

Green et al. (2003) conducted a Cochrane review to determine the efficacy of physiotherapy for disorders resulting in pain, stiffness and/or disability of the shoulder. Twenty-six trials met inclusion criteria. Methodological quality was variable, and population was small in the trials. The review noted that the trials resulted in little overall evidence to guide treatment; however, there is evidence to support the use of some interventions in specific and circumscribed cases. The authors indicate that there is a need for trials of physiotherapy interventions for specific conditions associated with shoulder pain. The trials should reflect clinical practice, where a combination of interventions is generally provided.

A Cochrane review by Thomson et al. (2002) examined physiotherapist-led programs and interventions for rehabilitation of anterior cruciate ligament, medial collateral ligament and meniscal injuries of the knee in adults. Thirty-one trials met inclusion criteria. It was noted that no trial provided sufficient evidence to establish the relative effectiveness of the interventions. The review included trials evaluating physiotherapist-led rehabilitation programs or components of rehabilitation programs and excluded trials that investigated electrical stimulation, cryotherapy, braces and continuous passive motion (CPM) devices used in initial or early treatment. It was noted that methodological quality was highly variable, and no trial provided sufficient evidence to establish the relative effectiveness of the interventions. The authors concluded that the available evidence is wide-ranging in terms of scope but insufficient to establish the relative effectiveness of the various approaches and methods in current use. There is a need for further research that involves good quality, large-scale randomized trials with adequate follow-up to completely assess knee function and recovery.

The Wessex Institute for Health Research and Development conducted an evidence review regarding outpatient physiotherapy services for low back pain (Fischbacher, 2001). The review “found that most primary studies examining the effects of individual treatments had generally poor methods, with small sample sizes (fewer than 50 subjects in each treatment group), short follow-up periods (usually less than six months) and low power.” The review concluded that it is difficult to draw conclusions regarding outpatient physiotherapy independent of the interventions within a particular service and that decisions to provide a physiotherapy service for back pain must pay close attention to the treatment modalities and protocols employed.

Aker et al. (1996) conducted a systematic review and meta-analysis to evaluate the efficacy of conservative management of mechanical neck disorders. Twenty-four randomized clinical trials met the selection criteria. Of these 24 studies, 12 trials involved physical medicine methods; nine used manual methods; four involved drug treatment; three provided education of patients; and four used more than one form of intervention. The findings from the review indicated that while many treatments are available and accepted as standard forms of practice, a systematic literature search finds a limited number of clinical trials. It was noted that there is early evidence to support the use of manual treatments in combination with other treatments for short-term pain relief but, in general, conservative interventions have not been studied in enough detail to assess efficacy or effectiveness adequately. They concluded that further clinical trials are needed to determine optimal treatment approaches.

### **Professional Societies/Organizations**

The American College of Rheumatology Subcommittee on Osteoarthritis Guidelines published recommendations for the medical management of osteoarthritis (OA) of the hip and knee (2000). The guidelines included the following notation regarding physical therapy: “Individuals with OA of the lower extremity may have limitations that impair their ability to perform activities of daily living (ADLs), such as walking, bathing, dressing, use of the toilet, and performing household chores. Physical therapy and occupational therapy play central roles in the management of patients with functional limitations. The physical therapist assesses muscle strength, joint stability, and mobility; recommends the use of modalities such as heat (especially useful just prior to exercise); instructs patients in an exercise program to maintain or improve joint range of motion and periarticular muscle strength; and provides assistive devices, such as canes, crutches, or walkers, to improve ambulation.”

The American Physical Therapy Association (APTA) published criteria for standards of practice for physical therapy (APTA, 2006). The criteria include the following regarding the plan of care:

- based on examination, evaluation, diagnosis, and prognosis
- identifies goals and outcomes
- describes the proposed intervention, including frequency and duration
- includes documentation that is dated and appropriately authenticated by the physical therapist who established the plan of care

The criteria note that the interventions are “consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care.” The criteria include the following notations regarding the interventions (APTA, 2006):

- based on the examination, evaluation, diagnosis, prognosis, and plan of care
- provided under the ongoing direction and supervision of the physical therapist
- altered in accordance with changes in response or status
- provided at a level that is consistent with current physical therapy practice

Regarding discharge and discontinuation of services, the criteria includes the following statements (APTA, 2006):

- The physical therapist discharges the patient/client from physical therapy services when the anticipated goals or expected outcomes for the patient/client have been achieved.
- The physical therapist discontinues intervention when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy.

### Summary

Physical therapy (PT) is a program of treatment rendered for the purpose of improving or restoring lost or impaired physical function resulting from illness, injury, congenital defect or surgery. PT should be structured, goal-directed, and individualized in nature. The therapy should be expected to result in expected to result in significant therapeutic improvement. While there are limited clinical trials published regarding the efficacy of specific PT interventions for specific conditions, it is considered a standard-of-care in management of musculoskeletal conditions.

## Coding/Billing Information

**Note:** This list of codes may not be all-inclusive.

**Covered when medically necessary:**

CPT <sup>®</sup> * Codes	Description
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy (eg, microwave)
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet

97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

<b>HCPCS Codes</b>	<b>Description</b>
G0151	Services of physical therapist in home or health setting, each 15 minutes
S9131	Physical therapy; in the home, per diem

<b>ICD-9-CM Diagnosis Codes</b>	<b>Description</b>
	Multiple/varied

**Training in Nature/Not Medically Necessary/Not Covered:**

<b>CPT* Codes</b>	<b>Description</b>
97005	Athletic training evaluation
97006	Athletic training re-evaluation
97150	Therapeutic procedure(s), group (2 or more individuals)
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work tack analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour

<b>HCPCS</b>	<b>Description</b>
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<b>Codes</b>	
S8990	Physical or manipulative therapy performed for maintenance rather than restoration
S9117	Back school, per visit

<b>ICD-9-CM Diagnosis Codes</b>	<b>Description</b>
	Multiple/varied

**\*Current Procedural Terminology (CPT®) ©2007 American Medical Association: Chicago, IL.**

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