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Occupational Therapy
Corporate Medical Policy

File Name: Occupational Therapy
File Code: 8.03.VT03
Origination: 01/1997
Last Review: 12/2020
Next Review: 12/2021
Effective Date: 04/01/2021

Description/Summary

Occupational Therapy promotes the restoration of a physically disabled person's ability to accomplish the ordinary tasks of daily living or the requirements of the person's particular occupation. Occupational Therapy must include constructive activities designed and adapted for a specific condition.

These services emphasize useful and purposeful activities to improve neuromuscular and musculoskeletal functions and to provide training in activities of daily living (ADL). Other occupational therapy services include the design, fabrication, and use of orthoses, and guidance in the selection and use of adapted equipment.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

Attachment I- CPT® Code List and Policy Instructions

When a service is considered medically necessary

Occupational therapy services are considered **medically necessary** when performed to treat the needs of a patient who suffers from physical impairment due to disease, trauma, congenital anomalies, or prior therapeutic intervention; and services must meet ***all*** of the following criteria:

- Only include those Occupational Therapy Services that require constant attendance of a licensed Occupational Therapist (OT), Occupational Therapy Assistant (OTA), Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.), Athletic Trainer (AT), Podiatrist (DPM), Advanced Practice Registered Nurse (APRN), or Doctor of Naturopathy (ND)
- Achieve a specific diagnosis-related goal for a patient who has a

reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time

- Provide specific, effective, and reasonable treatment for the patient's diagnosis and physical condition
- Be delivered by a qualified provider of occupational therapy services. A qualified provider is one who is licensed, where required, and performs within the scope of their licensure
- Require the judgment, knowledge, and skills of a qualified provider of occupational therapy services due to the complexity and sophistication of the therapy and the physical condition of the patient
- For ongoing services only when there is clear, measurable progress toward a rehabilitative goal, a less restrictive setting, or other Medically Necessary goal

Note: Occupational therapy services that include aqua and pool therapy must also meet all of the above criteria

Occupational Therapy for individuals diagnosed with Autism Spectrum Disorder (ASD):

Occupational therapy practitioners work with individuals with ASD, as well as parents, caregivers, educators, and other team members in a variety of settings, including the home, school, clinic, and community to assist the individual with successful participation and adaptation in school, home, and social environments. According to the American Occupational Therapy Association (AOTA), goals for young individuals with ASD frequently focus on enhancing an individual's sensory processing, sensorimotor performance, social/behavioral performance, self-care, and participation in play. In older individuals with ASD, occupational therapy goals focus on seven social/behavioral performance, activities of daily living and independence in the community.

The following components for the management of ASD may be considered medically necessary when the specified medical criteria apply. In accordance with the terms defined in the applicable medical policies, benefit contracts on these topics, or where a state mandate provides for such coverage, occupational therapy may be considered medically necessary when all of the following criteria are met:

- The individual has a documented Diagnostic and Statistical Manual of Mental Health (DSM-5) diagnosis of ASD and/or moderate to severe intellectual disability
- The individual has a history of a clinically significant impairment that interferes with the ability to negotiate their environment, communicate, learn, and/or demonstrate appropriate social behavior, which may include any of the following:
  - Impaired motor skills and/or musculoskeletal system involvement
  - Impaired activities of daily living
- The parent(s) and/or caregiver(s) are willing and able to participate and follow the training and support that is incorporated into the treatment plan.
- The therapy is rendered by or under the direction of a healthcare provider who is appropriately licensed to perform the therapy and who is eligible under the

terms of the member's benefit contract.
- The individual's progress in meeting the objectives of the treatment plan is measured on an ongoing basis for adjustment or refinement.

For Occupational Therapy services for ASD (for children through the age of 21, ending the day before their 22nd birthday), prior approval is required for additional visits beyond 30 combined physical therapy/occupational therapy/speech therapy (PT/OT/ST) visits.

The benefit for Occupational Therapy services, as treatment for eligible diagnoses refer to the Corporate Medical Policy Applied Behavior Analysis through age 21, is not subject to the combined 30 visit limit. When coverage for such therapies is authorized, unless a provider or the Plan determines an earlier assessment is required, the assessment of the individual's progress in meeting the objectives of the treatment plan shall be valid for six months. In order for benefits for Occupational Therapy to continue beyond the initial six-month period (or sooner if a shorter duration of need is determined in the initial evaluation), the provider must submit a progress report containing all applicable information outlined in this policy. Based on the information submitted, authorization for additional services may be extended for up to an additional six-month period if such services are determined to be medically necessary.

When a service is considered not medically necessary

Services not meeting the criteria above are considered **not medically necessary**. In addition, certain types of treatment do not generally require the skills of a qualified provider of Occupational Therapy services and are **not medically necessary**. These types of services may include (list may not be all inclusive):

- Repetitive exercises to improve walking and/or running distance, strength, and endurance assisted services in supporting unstable members;
- Passive range of motion (RPOM) treatment, not related to restoration of a specific loss of function;
- Preventive and maintenance activities;
- Treatment of behavioral problems;
- Treatment of intellectual disability;
- General conditioning program or self-monitored repetitive exercises or exercise equipment to increase strength and endurance;
- Therapy for a condition when the therapeutic goals of a treatment plan have been achieved and no progress is apparent or expected to occur;
- Any modality not listed in attachment I;
- Inpatient care if the hospital admission is solely for the purpose of receiving Occupational Therapy.

When a service is considered investigational

- Dry Needling
- Interactive Metronome
- Low Level Laser Therapy
- Vertebral axial decompression (i.e. DRS System, DRX 9000, VAX-D Table, Accu-

Spina System, Lordex Lumbar Spine System, Internal Disc Decompression (IDD) distraction table) (S9090)
- Thermal massage bed, hydrotherapy massage
- Therapeutic Magnetic Resonance (TMR)
- Active Therapeutic movements (ATMs)
- Whole body vibration therapy
- Whole body advance exercise
- Wobble Chair
- Oscillating platform therapy, Spineforce;
- Sensory integration therapy (including services under CPT code 97533)
- Gait analysis
- Hands-free ultrasound
- Iontophoresis and phonophoresis for drug delivery
- Aqua and pool therapy is considered investigational for all non-musculoskeletal indications (ie: asthma)
- OT services are considered investigational for treatment of ASD for individuals over the age of 21 years because published scientific literature does not support their effectiveness. OT may be eligible for members over the age of 21 years diagnosed with ASD if they meet medical necessity criteria for OT for other diagnoses where these therapies may be indicated.

When a service is considered a benefit exclusion and therefore not covered:

- Athletic training evaluation is an exclusion because the service is to establish or re-establish the capability to perform, hobby, sport or leisure activities and is a specific exclusion to the member contract
- Acupuncture, acupressure, or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. (This exclusion does not apply to Medically Necessary services that would otherwise be covered services when such services are performed by a Naturopathic provider and within the scope of the Naturopathic provider's license.)
- Biofeedback or other forms of self-care or self-help training
- Care for which there is no therapeutic benefit or likelihood of improvement
- Care, the duration of which, is based upon a predetermined length of time rather than the condition of the patient, the results of treatment, or the individual's medical progress
- Care provided, but not documented with clear, legible notes indicating patient's symptoms, physical findings, Physician's assessment, and treatment modalities used (billed)
- Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading, or writing skills
- Treatment of developmental delays. (This exclusion does not apply to mandated treatment of Autism Spectrum Disorder up to age 21 as defined by Vermont law.)
- Education, educational evaluation or therapy, therapeutic boarding schools, services that should be covered as part of and evaluation for, or inclusion in, a Child's individualized education plan (IFP) or other education program. (This

exclusion does not apply to treatment of diabetes, such a medical nutrition therapy by approved participating Providers.)

- Foot care or supplies that are Palliative or Cosmetic in nature, including supportive devices and treatment for bunions (except capsular or bone Surgery), flat-foot conditions, subluxations of the foot, corns, callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. (This exclusion does not apply to necessary foot care for treatment of diabetes.)
- Group physical medicine services, group exercise, or physical therapy performed in a group setting
- Treatment solely to establish or re-establish the capability to perform occupational, hobby, sports, or leisure activities
- Therapy services that are considered part of custodial care
- Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are covered by Workers' Compensation or should be so covered. (This provision does not require an individual, such as a sole proprietor or an owner partner to workers' compensation if he or she does not legally need to be covered.)
- Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, hippotherapy, music or art therapy, recreational therapy, tobacco cessation therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy
- Physical fitness equipment, braces, and devices intended primarily for use with sports, recreation, or physical activities other than Activities of Daily Living (e.g. knee braces for skiing, running, or hiking); weight loss or exercise programs, health club, or fitness center memberships are not a covered benefit
- Services, including modalities that do not require the constant attendance of a provider
- Dynamic splitting, patient-actuated end range motion stretching devices and programmable variable motion resistance devices
- Supervised services or modalities that do not require the skill and expertise of a licensed providers
- Unattended modalities/services. Application of a modality to one or more areas (application of a modality that does not require direct one on one patient contact by provider). This includes, but is not limited to:
  - Hot or cold packs
  - Electrical stimulation (unattended)
  - Paraffin bath
  - Whirlpool
  - Diathermy (eg, microwave)
  - Infrared
  - Ultraviolet
- Services beyond those needed to restore ability to perform Activities of Daily Living.

Habilitative and Rehabilitative Services

Habilitative and rehabilitative services are services provided to achieve normal functions and skills necessary to perform age-appropriate basic activities of daily living, including ambulation, eating, bathing, dressing, speech, and elimination.

Habilitation and rehabilitation services may include respiratory therapy, speech therapy, occupational therapy and physical medicine treatments. Habilitation and rehabilitation services may be performed by those who are qualified to perform such services and do so within the scope of their license. Such services are evaluated based on objective documentation of measurable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable, and evidence-based.

Habilitative services, including devices, are provided for a person to attain a skill or function never learned or acquired due to a disabling condition.

Rehabilitation services, including devices, wheareas, are provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

The following services are excluded from benefits under our certificates of coverage: custodial care, vocational, recreational, educational services, and services that show no likelihood of improvement and/or no therapeutic benefit.

Related Policies

Applied Behavior Analysis
Chiropractic Services
Cognitive Rehabilitation
Physical Therapy/Medicine
Speech Language Pathology/Therapy

Legislative Guidelines

V.S.A. § 3351-Occupational Therapists and Occupational Therapy Assistants
V.S.A. § 4088i-Early Childhood Developmental Disorders
Vermont Act 127- Autism Spectrum Disorders

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required for additional visits beyond 30 combined PT/OT/ST visits per plan year. Benefits are subject to all terms, limitations, and conditions of the subscriber contract or employer benefit plan.

Only medically necessary occupational therapy services are eligible for benefits. To be considered medically necessary the services must meet the guidelines outlined in the Policy section.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

The plan covers up to 30 habilitative and up to 30 rehabilitative outpatient sessions, ***combined for*** PT/OT/ST visits per plan year. This maximum applies to sessions provided in the home, an outpatient facility or professional office setting. The maximum number of visits included in covered benefits may vary for specific contracts or products. Please refer to the appropriate subscriber contract for the applicable benefit maximum.

Modality codes 97032 & 97035 are generally considered to be an adjunct to a variety of therapies and when billed by an allopathic, osteopathic, or chiropractic physician, these services will not apply to the defined benefit limit for PT, OT, and ST combined.

Modality codes 97032 & 97035 will only count as an individual Chiropractic visit if no other chiropractic services are rendered at the same visit.

When other therapeutic techniques (CPT 97110-97535) are billed by any provider (including a chiropractic physician) these services will apply to the defined benefit limit for PT, OT, and ST combined.

OT services in the Emergency Room will apply to the defined benefit limit for PT, OT, and ST combined.

OT services rendered at an inpatient level of care to members in an acute inpatient or rehabilitation facility, or under hospice care, do not apply to the defined benefit limit.

OT therapists are eligible to provide medically necessary DME, subject to the terms, conditions and limitations of the subscriber's contract and therapist provider contract.

If member visits one provider for PT and another provider for OT, this will count as 2 visits. If member visits one provider for PT and another provider for PT, this will count as 2 visits. If member visits one provider who provides both PT and OT during a single visit, this will count as one visit.

Evaluation

An Occupational Therapy evaluation is essential to determine if OT services are medically necessary, gather baseline data, establish a treatment plan, and develop goals based on that data. An evaluation is needed before implementing any OT treatment.

The plan of care should include:

- Prior functional level, if an acquired condition;
- Objective, measurable, and functional descriptions of an individual's deficits using comparable and consistent methods;
- Specific statements of long- and short-term goals;
- Measurable objectives;
- A reasonable estimate of when the goals will be met along with rehabilitation prognosis;
- The specific techniques and/or activities to be used in treatment;
- The frequency and duration of treatment;
- Discharge plan that is initiated at the start of OT treatment;
- All of the above required information will be documented with clear, legible notes that include the date of treatment and signature of the treating provider.

Progress Notes

Flowsheets are considered a component of the medical record but are not sufficient on their own unless they document the duration of treatment, modality parameters, total treatment time, settings, and if the provider was in constant attendance. This information must be included in the medical record, either in flowsheets or in the progress note, to support both the procedure codes billed and the medical necessity of procedures performed.

It is also required that documentation demonstrates the progression and improvement of exercises performed, treatment parameters for each, treatment times performed and the total treatment time for the daily sessions and if the therapist was one-on-one with the patient. When patients are performing independently on exercise equipment (e.g. treadmill, bike) and a provider is not in constant attendance for evaluation and instruction the provider should not bill for therapeutic procedures.

Documentation for Constant Attendance Procedures/Modalities
When documentation supports constant-attendance therapeutic procedures or modalities (i.e. 97110, 97112) are being performed, time documentation is required. The amounts of time versus the appropriate number of units to bill are as follows:

- If less than 8 minutes, use modifier 52 for reduced services
- If 8-22 minutes, bill 1 unit
- If 23-37 minutes, bill 2 units, etc

Sessions:

- An OT **session is defined as up to one hour of OT services** (treatment and/or evaluation) or up to three OT modalities provided on any given day.
- Billing for the three modalities cannot exceed one hour per session.

A self-pay agreement must be entered into with the member prior to rendering any services described in this policy when member chooses to pay, at their own expense, for services that exceed the limitations of coverage (i.e. visits beyond the 30 combined visit limit per plan year) or any other excluded or non-covered services (i.e. wellness/preventative physical therapy); care designed to prepare for specific occupational, leisure, or recreational activities or hobbies or sports; acupuncture or massage therapy (this list of examples is not all-inclusive). This self-pay agreement must be maintained as part of the member's medical record.

Policy Implementation/Update information

Update: 12/2002 07/2003 09/2004 04/2005	ICD-9 2003 codes changes. Included TVHP, updated attachments. This policy replaces PT/OT policy signed by F. Balco 01/08/1998, effective 01/1997, memo from B. Miglarese dated 03/29/1991 and memo from pricing and coding dated 5/19/1997.
10/2005	PT, ST, OT policies combined into one and updated
10/2006	updated with CPT and diagnoses codes added and minor wording changes
10/2007	Updated format and minor changes made to match current certificate language. Reviewed by CAC 01/2008.
10/2008	Updated. Reviewed by CAC 01/2009
05/2009	ST component removed to separate policy
11/2010	OT component removed to separate policy, updated, diagnosis codes deleted, additional exclusions added (Iontophoresis, phonophoresis, hippotherapy)

08/2011	Updated policy extracted to revised format, grammatical corrections made to allow policy language to fit new format. Autism Mandate Language inserted.
10/2011	Medical Clinical Coder reviewed and approved SAF
05/2012	removed six months after initiation language
09/2012	Updated policy to reflect ECDD mandate. Minor format changes and some coding additions and changes. Added "audit information" and "legislative guidelines" section. Medical/Clinical Coder RLJ.
11/2013	Added Habilitative language to policy as mandated by Section 1302of the Affordable Care Act. ICD changes to reflect changes to Autism and ECDD policies.
02/2014	ICD-10 remediation only. The *disallowed diagnosis* column under ICD-9 column was removed. Only allowed diagnoses are listed. RLJ
06/2015	Group physical medicine clarified. Unattended modalities clarified as a contract exclusion. Exclusion for bunion care added. HCPCS S8990 moved to exclusion. Diagnosis code table removed. Benefits for services outlined in this policy are no longer diagnosis driven. Reviewed and approved by MPC on: 6/22/15.
01/2016	Modality CPTs 97012 & 97016 moved as eligible section. Moved Athletic training evaluation CPT (97005 & 97006) to exclusions section per member contracts. Reviewed and approved by MPC on: 1/11/16.
12/2016	Updated formatting for Habilitative and Rehabilitative definitions.

07/2018	Updated description section. Added language around Autism Spectrum Disorder. Updated eligible providers section. Updated Legislative Guidelines section. Removed NP under eligible providers, same as APRN. Moved Dynamic splinting from investigational to benefit exclusion section; moved Hubbard tanks and contrast baths from not medically necessary to medically necessary section of policy. Moved Equestrian /Hippo Therapy from not medically necessary to investigational. Clarified modality code 97542 (Wheelchair Fitting) do not count against benefit limits. Added -SZ modifier for habilitative vs rehabilitative and updated coding table. Added 2017 CPT® Codes (97165, 97166, 97167, 97168, 97169, 97170, 97171& 97172). Deleted codes (97003, 97004, 97005 &97006). Moved Group therapy 97150 to benefit exclusion from not medically necessary. 01/01/2018: Adaptive Maintenance: Revised CPT® codes for effective date 01/01/2018 A new code 97127 was added for therapeutic interventions specific to cognitive function and strategies to compensate and manage activity performance with direct patient contact. This code can only be reported once per day. Code 97532 was deleted, and the service would now be reported with the new code. Codes 97760 and 97761 were revised to be specific to the initial encounter and a new code 97763 was added for subsequent. Code 97762 was deleted, and the service would now be reported with the new code. Removed –SZ modifier and added -96 modifier to the coding table. G0515 Added. 99483 added can only be reported every 180 days.
03/2019	Added clarifying language for ASD and prior approval requests: For Physical Therapy services for ASD (for children through the age of 21, ending the day before their 22nd birthday), prior approval is required for additional visits beyond 30 combined sessions of PT/OT/ST visits.
01/2020	Adaptive Maintenance Updates: Deleted Code 97127 effective 01/2020. Added under “Related Policies” section Cognitive Rehabilitation. Moved codes 99483 & G0515 to Cognitive Corporate Rehabilitation Medical Policy.
12 /2020	Policy reviewed. Removed codes 97012& 97016 from being covered to not covered to align certificate language. Added detail about what constitutes an OT session.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors Date Approved

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Kate McIntosh, MD, MBA, FAAP
Senior Medical Director

Attachment I
CPT® Code List and Policy Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	Physical medicine and rehabilitation modalities (**constant attendance**). For this code range, services are measured in 15-minute time units. Time must be documented. Units are required in addition to the code for billing with one unit equaling 15 minutes.
CPT®	97034	Contrast baths, each 15 minutes	
CPT®	97035	Application of a modality to 1 or more areas; Ultrasound, each 15 minutes	
CPT®	97036	Application of a modality to 1 or more areas; Hubbard Tank, each 15 minutes	
CPT®	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	
CPT®	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	
CPT®	97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	
CPT®	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	

CPT®	97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	
CPT®	97165	Occupational therapy evaluation, moderate complexity, requiring these components	
CPT®	97166	Occupational therapy evaluation, moderate complexity, requiring these components	
CPT®	97167	Occupational therapy evaluation, high complexity, requiring these components	
CPT®	97168	Re-evaluation of occupational therapy established plan of care, requiring these components	
CPT®	97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	
CPT®	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	
CPT®	97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	
CPT®	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	
CPT®	97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes	

CPT®	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, initial encounter	
CPT®	97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes, initial encounter	
CPT®	97763	Orthotic(s)/prosthetic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes. Subsequent encounter.	
HCPCS	G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	
HCPCS	S8950	Complex lymphedema therapy, each 15 minutes	
HCPCS	S9129	Occupational therapy; in the home, per diem	
Modifier	-96	Habililitative Services	This modifier must be reported when habilitative services are provided. This will allow for services to accumulate to the correct benefit limit.
Modifier	-97	Rehabilitative Services	This modifier must be reported when rehabilitative services are provided. This will allow for services to accumulate to the correct benefit limit.
Revenue Codes	0430 0431 0432 0434 0439 0978	Occupational therapy Revenue codes	

The following codes will be denied as Not Medically Necessary			
CPT®	97039	Unlisted modality (specify type and time if constant attendance)	Not Medically Necessary
CPT®	97139	Unlisted therapeutic procedure (specify)	Not Medically Necessary
The following codes will be denied as Investigational			
CPT®	96000	Comprehensive computer-based motion analysis by videotaping and 3D kinematics;	Investigational
CPT®	96001	Comprehensive computer-based motion analysis by videotaping and 3D kinematics; with dynamic plantar pressure measurements during walking	Investigational
CPT®	96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	Investigational
CPT®	96003	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle	Investigational
CPT®	96004	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	Investigational
CPT®	97033	Iontophoresis, each 15 minutes	Investigational
CPT®	97533	Sensory integrative techniques, to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	Investigational
CPT®	97799	Unlisted physical medicine/rehabilitation service or procedure	Investigational

HCPCS	S9090	Vertebral axial decompression, per session	Investigational
The following codes are considered contract exclusions and therefore are NOT covered			
CPT®	97010	Hot and/or cold packs	The following codes represent modalities which do not require the constant attendance of a trained physical therapist, and therefore are excluded from coverage.
CPT®	97012	Traction, mechnical	
CPT®	97014	Electrical stimulation (unattended)	
CPT®	97016	Vasopneumatic devices	
CPT®	97018	Paraffin bath	
CPT®	97022	Whirlpool	
CPT®	97024	Diathermy (eg., microwave)	
CPT®	97026	Infrared	
CPT®	97028	Ultraviolet	
CPT®	90901	Biofeedback training by any modality	
CPT®	90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	Not Covered
CPT®	97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not Covered
CPT®	97150	Therapeutic procedure, group Athletic training re-evaluation	Not Covered
CPT®	97169	Athletic training evaluation, low complexity, requiring these components	Not Covered
CPT®	97170	Athletic training evaluation, moderate complexity, requiring these components	Not Covered
CPT®	97171	Athletic training evaluation, high complexity, requiring these components	Not Covered
CPT®	97172	Re-evaluation of athletic training established plan of care requiring these components	Not Covered

CPT®	97537	Community/ work integration training (eg., shopping transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minute	Not Covered
CPT®	97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	These services may be eligible if the member's group has purchased the Acupuncture rider
CPT®	97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure	These services may be eligible if the member's group has purchased the Acupuncture rider
CPT®	97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	These services may be eligible if the member's group has purchased the Acupuncture rider
CPT®	97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)	These services may be eligible if the member's group has purchased the Acupuncture rider
CPT®	97545	Work hardening/conditioning; initial 2 hours	Not Covered
CPT®	97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	Not Covered

HCPCS	G0281	Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	Not Covered
HCPCS	G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	Not Covered
HCPCS	G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	Not Covered
HCPCS	S8990	Physical or manipulative therapy performed for maintenance rather than restoration	Not Covered
HCPCS	S8940	Equestrian/Hippotherapy, per session	Benefit Exclusion