PURPOSE

This bulletin notifies Medicare Advantage participating hospitals and skilled nursing facilities that Highmark’s Medicare Advantage Medical Policy Y-1, titled “Physical Medicine and Rehabilitation Services, PT and OT,” will be applied to facility business for claims submitted on and after October 1, 2011, the date of the applicable Local Coverage Determination. The bulletin also provides a summary of key provisions of Medicare Advantage Medical Policy Y-1, to help facility providers prepare to comply with its requirements.

BACKGROUND/OVERVIEW

Highmark’s Physical Medicine Management Program: Two Components
Bulletin HOSP-2012-011-W/MPC-2012-008-W announced the September 1, 2012 launch of Highmark’s Physical Medicine Management Program. The bulletin focused on the processes through which providers of physical medicine services will interact with Healthways WholeHealth Networks, Inc., the administrator of the Program, to ensure that physical medicine services provided to Highmark members are clinically indicated, medically necessary and in accordance with member benefits.

The other major component of the Physical Medicine Management Program involves the implementation of Highmark’s medical policies governing physical medicine services. Medicare Advantage Medical Policy Y-1 is one of these policies. It applies to outpatient rehabilitative services, including physical medicine and occupational therapy, rendered to members with coverage under Highmark’s Medicare Advantage products and billed by participating facility and professional providers on and after DATE.

Physical Medicine and Rehabilitative Services
Physical medicine and rehabilitative services are designed to improve, restore and/or compensate for loss of physical functioning following disease, injury or loss of a body part. Physical medicine and rehabilitation services are covered when performed with the expectation of improving, restoring and/or compensating for loss of the patient’s level of function which has been lost or reduced by injury or illness. Therapy performed repetitively to maintain the same level of function is not eligible for reimbursement.
Services that can be safely and effectively furnished by non-skilled personnel without the supervision of a qualified professional are not rehabilitative services. If at any point in the treatment of an illness, it is determined that the treatment is not rehabilitative, or does not legitimately require the services of a qualified professional for management of a maintenance program, the services will no longer be considered reasonable and necessary.

**Procedure Codes Included in Medicare Advantage Medical Policy Y-1**
The following is a list of procedure codes representing services to which the medical necessity guidelines of Medicare Advantage Medical Policy Y-1 apply:

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Specific diagnosis codes applicable to the procedures identified above are provided in the two attachments to this bulletin. The first pertains to all the procedures above except for 97026 (*Infrared Therapy*); the second pertains exclusively to procedure 97026.

**Evaluations and Re-Evaluations (97001-97004)**
Coverage is provided for an evaluation that is reasonable and necessary for the clinician to determine if there is an expectation that the services will be appropriate for the patient’s condition. During the first patient contact, the clinician evaluates and documents the following:

- An impairment-based diagnosis and description of the specific problem evaluated and/or treated, including the specific body part(s) evaluated and all the conditions and complexities that may impact treatment;
- Objective measurements, that may include standardized patient assessment instruments and/or outcomes measurement tools related to current physical and functional status, when these are available and appropriate to the condition being evaluated;
- Clinician’s clinical judgments that describe impairments and the current functional status of the patient; and
- A determination of whether or not the treatment is needed, and a prognosis for return to pre-morbid condition or maximum expected condition with expected time frame and a plan of care.

A re-evaluation is the re-assessment of the patient’s performance and goals, after an intervention plan has been established, in order to determine the type and amount of change in treatments if needed. Re-evaluation requires the same professional skill as evaluation. Continuous assessment of the patient’s progress is a component of ongoing therapy services, and is not a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or
Modalities
The use of modalities may be reasonable and necessary in many clinical situations. Documentation in the patient’s medical record should support the use of multiple modalities as contributing to the patient’s progress with improving, restoring and/or compensating for loss of function, and as per the plan of care. When more than one modality is used during an encounter -- whether supervised or constant attendance, or any combination -- each modality provided should be reported and reflected in the documentation. This documentation must be made available upon request.

Mechanical Traction Therapy (97012)
Traction is generally used for joints, especially of the lumbar or cervical spine, with the expectation of relieving pain in or originating from those areas, or increasing the range of motion of the joint. Specific indications for the use of mechanical traction include but are not limited to cervical and/or lumbar radiculopathy, and back disorders such as disc herniation, lumbago and sciatica.

Electrical Stimulation (Unattended) (G0283)
Unattended electrical stimulation is the use of current to facilitate the reduction of pain, edema and muscle spasm, as well as to increase contractile force in the muscles. The type and frequency of current placement of electrodes and duration of treatment are determined by the clinician.

Diathermy Treatment (97024)
Diathermy is a modality for heating skeletal muscle. The use of diathermy is considered reasonable and necessary for the delivery of heat to deep tissues such as skeletal muscle and joints for the reduction of pain joint stiffness, and muscle spasm.

High energy pulsed wave diathermy machines have been determined to produce the same therapeutic benefit as standard diathermy; therefore, these treatments are considered reasonable and necessary for the same indications as standard diathermy. Diathermy is not considered reasonable and necessary for the treatment of asthma, bronchitis or any other pulmonary condition.

Contrast Baths (97034)
Contrast bath therapy is the alternate immersion of a body part in hot water and cold water. Specific indications for the use of contrast baths include but are not limited to the patient having rheumatoid arthritis, other inflammatory arthritis, reflex sympathetic dystrophy, or a sprain or strain resulting from an acute injury.

Ultrasound (97035)
Therapeutic ultrasound is a deep heat modality. The application of ultrasound is considered reasonable and necessary for patients requiring deep heat to a specific area for reduction of pain, spasm and joint stiffness, and to increase the flexibility of muscles, tendons and ligaments.

Specific indications for the use of ultrasound application include but are not limited to the patient having neuromas, symptomatic soft tissue calcification or tightened structures limiting joint motion that require an increase in extensibility.
Ultrasound application is not considered to be reasonable and necessary for the treatment of asthma, bronchitis or any other pulmonary condition.

**Therapeutic Procedures (97110-97546)**

Therapeutic procedures are treatments that attempt to reduce impairments and improve, restore and/or compensate for loss of function through the application of clinical skills and/or services. Therapeutic exercises and neuromuscular reeducation are examples of therapeutic interventions. Documentation must support the use of each treatment or modality as it relates to a specific therapeutic goal. Services provided by qualified health care providers of different types (e.g., physical therapists and occupational therapists) may be covered if separate and distinct goals are documented in the separate treatment plans. Concurrent care cannot be billed at the same time.

**Aquatic Therapy with Therapeutic Exercises (97113)**

This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). The procedure may be reasonable and medically necessary for a loss or restriction of joint motion, strength mobility or function which has resulted from a specific disease or injury. This requires direct (one-on-one) patient contact. However, the therapist does not have to be in the water. This code is to be used for any exercise performed in a water environment.

Documentation should include objective findings related to joint motion, strength, or mobility impairments (e.g., degrees or motion, strength grades, levels of assistance) and reflect the medical necessity of the treatment in a water environment. Other forms of exercise therapy may be medically necessary in addition to aquatic therapy.

**An Important Note about Hydrotherapy**

It is not considered medically necessary to have more than one form of hydrotherapy (e.g., 97022, 97036, 97113) during a visit.

**Gait Training (97116)**

Gait training is the training of the biomechanical and kinesiological components of walking, including balance, cadence symmetry, motor control, speed and energy efficiency. This procedure may be reasonable and necessary to improve, restore and/or compensate for impairment of walking ability due to neurological, muscular or skeletal abnormalities or trauma.

Specific indications for gait training include but are not limited to the following:

- The patient having suffered a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation
- The patient having recently suffered a musculoskeletal trauma, requiring ambulating reeducation
- The patient having a chronic, progressively debilitating condition for which safe ambulation has recently become a concern
- The patient having had an injury or condition that requires instruction in the use of an assistive device, e.g., walker, crutches or cane
- The patient having been fitted with a brace/lower limb prosthesis and requires instruction in ambulation
- The patient having a condition that requires training in stairs/steps or chair transfer in addition to general ambulation

Gait training is not considered reasonable and necessary when the patient’s walking ability is not expected to improve. Supervised ambulation in the absence of the delivery of skilled services is not reportable.

**Massage (97124)**
Massage, which is designed to facilitate healing of muscles, reduce edema, improve joint motion and/or relieve muscle spasm, may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day. Massage includes effleurage, petrissage and/or tapotement (stroking, compression, percussion). Documentation should support the medical necessity for therapeutic massage.

**Manual Therapy Techniques (97140)**
Manual therapy techniques consist of, but are not limited to, joint mobilization and manipulation, manual lymphatic drainage, manual traction and soft tissue mobilization. Providers use their hands to administer these techniques. Therefore, code 97140 describes “hands-on” therapy techniques. Typically, the goals of manual therapy are to modulate pain, increase joint range of motion, and reduce or eliminate soft tissue swelling inflammation or restriction. These techniques also induce relaxation and improve contractile and non-contractile tissue extensibility.

Manual therapy techniques can be performed on individuals with symptoms that may include a limited range of motion, muscle spasm, pain, scar tissue or contracted tissue, and/or soft tissue swelling, or inflammation.

1. **Manual traction**
   This procedure may be considered reasonable and necessary for cervical radiculopathy and cervicalgia.

2. **Joint mobilization (peripheral or spinal)**
   This procedure may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.

3. **Soft tissue mobilization, one or more regions**
   This technique may be medically necessary for treatment of restricted motion of soft tissues. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissue articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, or stretching of shortened muscular, scar or connective tissue. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.

4. **Manual lymphatic drainage** is a manual technique utilized to facilitate the movement of excessive lymphatic fluid. This technique is independent of exercise and compression services that are usually provided on the same date of service. It may be medically necessary when the following conditions are met: there is a physician-documented diagnosis of lymphedema; the patient is symptomatic for lymphedema, with limitation of function; and
the patient or patient caregiver has the ability to understand and comply with home care continuation of treatment regimen.

5. **Manipulation**

**Therapeutic Activities (97530)**
Therapeutic activities are considered reasonable and necessary for patients needing a broad range of rehabilitative techniques that involve movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, overhead activities and performance of transitional movements or activities) to improve, restore, and/or compensate for loss of functional performance, including, where applicable, performance of transitional movements, in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the skills of a clinician and are designed to address a specific functional need of the patient.

Therapeutic activities may be medically necessary when the professional skills of a clinician are required, and the activity is designed to address a specific need of the patient. These dynamic activities must be part of a documented treatment plan and intended to result in a specific outcome.

**Development of Cognitive Skills (97532)**
This code describes interventions used to enhance cognitive skills (e.g., attention, memory, problem solving) with direct (one-on-one) patient contact by the clinician. It may be medically necessary for patients with acquired cognitive impairments from head trauma, acute neurological events (including cerebrovascular accidents), or other neurological disease.

**Self-Care/Home Management Training (97535)**
This training includes activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment, and requires direct one-on-one contact by the qualified professional. The patient must have a condition for which training in activities of daily living is reasonable and necessary, and such training must be reasonably expected to improve, restore and/or compensate for loss of functioning of the patient. The patient and/or caregiver must have the capacity to learn from instructions.

This procedure is reasonable and necessary only when it requires the skills of a clinician is designed to address specific needs of patient, and is part of an active treatment plan directed at a specific outcome. Documentation must relate the training to expected functional goals that are attainable by the patient.

**Community Reintegration (97537)**
Community reintegration procedures for the patient are reasonable and necessary only when they require the specific skills of a clinician are designed to address specific needs of the patient, and are part of an active treatment plan directed at a specific outcome. The treatment plan may be aimed at improving, restoring, and/or compensating for loss of specific functions that were impaired by an identified illness or injury, and when the expected outcomes, that are attainable by the patient, are specified in the plan. Generally speaking, physical medicine and rehabilitative services are not required to effect improvement or restoration of function where a patient suffers a temporary loss or
reduction of function which should be expected to spontaneously improve as the patient gradually resumes normal activities.

**Wheelchair Management (97542)**
Wheelchair management includes assessment of the need for a wheelchair, determination of the type of wheelchair and wheelchair components, measuring for and fitting the wheelchair, making adjustments, and training in the use of the chair. This procedure is reasonable and necessary only when it requires the skills of a qualified professional, is designed to address specific needs of the patient, and is part of an active treatment plan directed at a specific goal. When billing 97542, it is expected that the documentation will relate the training to expected functional goals attainable by the patient and/or caregiver.

**Work Hardening/Conditioning (97545 and 97546)**
Work hardening services relate solely to specific work skills. They are considered not medically necessary for the diagnosis or treatment of illness or injury.

**Prosthetic Training (97761)**
Prosthetic training is the professional instruction necessary for a patient to properly use an artificial device that has been developed to replace a missing body part. This procedure is considered reasonable and necessary if there is an indication for education on the application of the prosthesis, and/or use of the prosthesis, in all applicable environments.

**Checkout for Orthotic/Prosthetic Use (97762)**
Orthotic/prosthetic checkout is an end-service for an established patient that is used to report the time spent to ensure a correct fit when using the orthotic or prosthetic during functional activities. These assessments are reasonable and necessary when there is a modification or re-issue of a device or a reassessment of a newly issued device. These assessments may be reasonable and necessary when patients experience a loss or change in function directly related to the device (e.g., pain, skin breakdown or change in edema). Documentation in the medical record should support the medical necessity of the orthotic prosthetic checkout.

**Heat Modalities (97024, 97035)**
Heat modalities used for the treatment of asthma, bronchitis and other pulmonary conditions are considered not reasonable and necessary and will be denied.

**IMPACT/ACTION**

**Become Familiar with the Requirements of the Medical Policy Component of Highmark’s Physical Medicine Management Program**
Providers are asked to familiarize themselves with the requirements of Medicare Advantage Medical Policy Y-1 and to make whatever changes are necessary in their internal processes to ensure compliance.

Facilities can access Highmark’s Medicare Advantage Medical Policy from the NaviNet Provider Resource Center by following the Medical & Claims Payment Guidelines link to the Medical Policy Selection page, selecting Medicare Advantage Medical Policy and utilizing the appropriate search
Be Aware of Differences from the Corresponding Commercial Medical Policies
As a reminder, the medical policies that apply to Highmark’s Medicare Advantage members are based upon Medicare National and Local Coverage Determinations and may therefore differ from the medical policies that apply when the member has Commercial coverage.

Services That Do Not Meet the Medical Necessity Criteria of Medicare Advantage Medical Policy Y-1
Services that do not meet the medical necessity criteria stated will be denied as not medically necessary. A participating, preferred or network provider cannot bill the member for the denied service unless the provider has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of the cost. The member must agree in writing to assume financial responsibility, in advance of receiving the service. The signed agreement, in the form of a Pre-Service Denial Notice, should be maintained in the provider’s records. If the provider elects to submit the claim for payment, it must append modifier –GA (“Waiver of Liability on File”) to the procedure code for the service, to indicate that the Pre-Service Denial Notice form is on file.

Medicare Advantage Medical Policy Y-1 will apply to facility business effective for claims submitted on or after October 1, 2011.

Resources for the Physical Medicine Management Program
Facility and professional providers have access to a variety of resources – including a comprehensive Administrative Guide, forms, reference materials and training resources – via a dedicated Physical Medicine Management Program page on the Provider Resource Center. To access it, follow the Clinical Reference Materials link from the Provider Resource Center.

Questions regarding this bulletin should be directed to Highmark’s Medicare Advantage Facility Customer Service staff at 1-866-588-6967.

Inquiries about Eligibility, Benefits, Claim Status or Authorizations
For inquiries about eligibility, benefits, claim status or authorizations, Highmark encourages providers to use the electronic resources available to them – NaviNet® and the applicable HIPAA transactions – prior to placing a telephone call to Facility Customer Service.

ATTACHMENTS

Diagnosis Codes Applicable to Physical Medicine and Rehabilitative Services Procedures EXCEPT 97026, from Medicare Advantage Medical Policy Y-1

Diagnosis Codes Applicable to Physical Medicine and Rehabilitative Services Reported Under Procedure Code 97026, from Medicare Advantage Medical Policy Y-1

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