Policy Number	**THE803.010**
Policy Effective Date	**01/01/2026**

Physical Therapy (PT) and Occupational Therapy (OT) Services

Table of Contents
Coverage
Policy Guidelines
Description
Rationale
Coding
References
Policy History

Related Policies (if applicable)
THE803.020 Sensory Integration Therapy and Auditory Integration Therapy
THE803.021 Vertebral Axial Decompression
DME101.037 Pelvic Floor Stimulation as a Treatment of Urinary or Fecal Incontinence
THE803.019 Cognitive Rehabilitation
THE801.003 Hyperbaric Oxygen Therapy (HBOT)
DME101.050 Noncontact Warming Therapy and Fluorescence Imaging for Wounds
MED201.033 Functional Neuromuscular Electrical Stimulation
MED201.045 Low-Level Laser Therapy
MED201.047 Vestibular Function Testing
DME101.023 Continuous Passive Motion in the Home Setting

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0458 [Insurance Code 215 ILCS 5/356z.61] (HB3809 Impaired Children) states all group or individual fully insured PPO, HMO, POS plans amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for therapy, diagnostic testing, and equipment necessary to increase quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

Coverage

Outpatient physical and occupational therapy services **may be considered medically necessary** for **ALL** of the following:

1. Service provided under established plan of care, as indicated by **ALL** of the following:
   A. Therapy plan of care is developed by appropriate type of provider, as indicated by **1 or more** of the following:
      - Service is provided in comprehensive outpatient rehabilitation facility (CORF), and plan of care is established by physician;
      - Service is provided in setting other than a comprehensive outpatient rehabilitation facility (CORF) and plan of care is established by **1 or more** of the following:
        - Physician/non-physician provider (NPP);
        - Physical therapist who will provide physical therapy service;
        - Occupational therapist who will provide occupational therapy service.

   B. Plan is certified by a physician/NPP.
   C. Plan of care supports **1 or more** of the following:
      - Goal of plan of care is to improve functioning (rehabilitative therapy) and **ALL** of the following:
        - Documentation establishes patient need of the unique skills of a therapist to improve functioning.
        - Therapy is appropriate for the patient, as indicated by **ALL** of the following:
          a) Patient's condition has potential to improve or is improving in response to therapy; and
          b) Maximum improvement is yet to be attained; and
          c) There is expectation that anticipated improvement is attainable in reasonable and generally predictable period of time.
        - Service provided meets description of skilled therapy, as indicated by **1 or more** of the following:
          a) Service is of such a level of complexity that it can only be safely and effectively performed by a qualified clinician or therapist supervising assistant.
          b) Condition of patient is such that service can only be safely and effectively performed by a qualified clinician or therapist supervising assistant.
      - Goal of plan of care is to maintain, prevent, or slow further deterioration of functional status function or prevent deterioration (maintenance therapy) and **ALL** of the following:
        - Documentation establishes patient needs of the unique skills of a therapist to maintain, prevent, or slow further deterioration of functional status; and
        - Service provided meets description of skilled therapy, as indicated by **1 or more** of the following:
          a) Specialized skills, knowledge, and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration.
          b) Skilled therapy service by qualified therapist is needed to instruct patient or appropriate caregiver regarding maintenance program.

c) Skilled therapy service is needed for periodic re-evaluation or reassessment of maintenance program.
d) Skilled care is necessary for performance of a safe and effective maintenance program and **1 or more** of the following criteria are met:
   - Therapy procedure required to maintain patient's current function or to prevent or slow further deterioration is of such complexity and sophistication that skills of qualified therapist is required to furnish therapy procedure.
   - Patient's special medical complications require skills of qualified therapist to furnish therapy service required to maintain patient's current function or to prevent or slow further deterioration, even if skills of therapist are not ordinarily needed to perform such therapy procedure.

2. Service provided is specific and effective treatment for patient's condition according to accepted standards of medical practice, and amount, frequency, and duration of service must be reasonable.
3. Service is provided by personnel authorized to provide outpatient therapy services within scope of practice, as indicated by **1 or more** of the following:
   A. Physician;
   B. Non-physician practitioner (NPP) (physician assistant, nurse practitioner, clinical nurse specialist);
   C. Qualified physical and occupational therapist, and assistant working under supervision of qualified therapist;
   D. Qualified personnel, with or without a license to practice therapy, who has been educated and trained as a therapist and qualifies to furnish therapy services only under direct supervision incident to physician or NPP.
4. Specific procedure and modality guideline is met, as indicated by **1 or more** of the following:
   A. Physical therapy evaluation and occupational therapy evaluation, completed by therapist or physician/NPP that will be providing therapy service, for patient with change in functional status.
   B. Physical therapy re-evaluation and occupational therapy re-evaluation.
   C. Hot or cold pack to one or more areas, including ice massage, when used in conjunction with an associated procedure or modality.
   D. Traction, mechanical to one or more areas for relief of pain generally originating from cervical or lumber spine.
   E. Vasopneumatic device therapy for application of pressure to extremity for purpose of reducing edema or lymphedema (specific indications include reduction of edema after acute injury or lymphedema of extremity).
   F. Paraffin bath therapy, for complicated condition where unique skills, knowledge, and judgment of therapist are required.
   G. Whirlpool therapy when therapist supervision is medically necessary for **1 or more** of the following:
      - Condition complicated by circulatory deficiency or areas of desensitization;

- Open wound, which is draining, has foul odor, or necrotic tissue; or
- Exfoliative skin impairment.

H. Diathermy (i.e., microwave) when large area of deep tissue requires heat.
I. Ultraviolet therapy for a patient requiring application of drying heat.
J. Electrical stimulation (to one or more areas) for a patient with intact nerve supply to muscle, and other non-neurologic reason.
K. Iontophoresis to one or more areas for treatment of intractable, disabling, primary focal hyperhidrosis that has not been responsive to recognized standard therapy.
L. Contrast bath therapy when skills, knowledge, and judgment of therapist is required (e.g., where patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fracture, or other complication).
M. Ultrasound (pulsed or continuous width) when used in conjunction with therapeutic procedure (not as isolated treatment).
N. Hubbard tank to one or more areas when qualified professional/auxiliary personnel one-on-one supervision of patient is required.
O. Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of therapy plan of care.
P. Therapeutic exercise to develop strength and endurance, range of motion, and flexibility where loss or restriction is result of specific disease or injury and has resulted in functional limitation.
Q. Neuromuscular re-education for restoring prior function that has been affected by **1 or more** of the following:
    - Loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of feet, lower legs, and/or fingers;
    - Nerve palsy, such as peroneal nerve injury causing foot drop;
    - Muscular weakness or flaccidity as result of cerebral dysfunction, nerve injury, or disease or having had spinal cord disease or trauma;
    - Poor static or dynamic sitting/standing balance;
    - Postural abnormality;
    - Loss of gross and fine motor coordination; or
    - Hypo/hypertonicity.
R. Aquatic therapy with therapeutic exercise for one or more areas, for **1 or more** of the following:
    - Loss or restriction of joint motion, strength, mobility, balance, or function due to pain, injury, or illness by using buoyancy and resistance properties of water;
    - Patient without ability to tolerate land-based exercise for rehabilitation.
S. Gait training, including stair climbing, for training patient and instructing caregivers in ambulating patient whose walking ability has been impaired by neurologic, muscular, or skeletal abnormality or trauma.
T. Massage therapy, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion) to one or more areas as adjunctive treatment to another therapeutic procedure on same day, that is designed to reduce edema, improve joint motion, or relieve muscle spasm.

U. Manual therapy technique (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), to one or more regions, for **1 or more** of the following:
   - Manual traction for cervical dysfunction such as cervical pain and cervical radiculopathy;
   - Joint mobilization (peripheral and/or spinal) if restricted or painful joint motion is present and documented;
   - Joint mobilization (peripheral and/or spinal) as adjunct to therapeutic exercise when loss of articular motion and flexibility impedes therapeutic procedure;
   - Myofascial release/soft tissue mobilization for treatment of restricted motion of soft tissues in involved extremity, neck, and trunk;
   - Manipulation for treatment of painful spasm or restricted motion in periphery, extremities, or spinal regions;
   - Manual lymphatic drainage/complex decongestive therapy for both primary and secondary lymphedema, and **ALL** of the following:
     - Physician-documented diagnosis of lymphedema (primary or secondary); and
     - Patient has documented signs or symptoms of lymphedema; and
     - Patient or patient caregiver has ability to understand and comply with continuation of treatment regimen at home.

V. Therapeutic procedure(s), group (2 or more individuals).
   - Therapeutic activity for a patient needing broad range of rehabilitative techniques that involve movement and **ALL** of the following:
     - Patient has documented condition that therapeutic activity can reasonably be expected to restore or improve functioning; and
     - There is clear correlation between type of therapeutic activity performed and patient's underlying medical condition; and
     - Patient's condition is such that he/she is unable to perform therapeutic activity without skilled intervention of qualified professional/auxiliary personnel.

W. Self-care/home management training (e.g., ADL and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), and **ALL** of the following:
   - Service requires skills of therapist; and
   - Designed to address specific needs of patient; and
   - Is part of active treatment plan directed at specific outcome; and
   - Patient has condition for which self-care/home management training is reasonable and necessary; and
   - Patient and/or caregiver must have capacity and willingness to learn from instructions.

X. Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities, and/or work environment/modification analysis, work task analysis), for **1 or more** of the following:
   - Performed in conjunction with patient's individual treatment plan aimed at improving or restoring specific community functions that were impaired by

identified illness or injury and when realistically expected outcome is specified in the plan.

- Provision of compensatory training of patient in driving technique, and **ALL** of the following:
  - Need for therapy is result of identified injury or illness, not simply generalized aging, weakness, or debility; and
  - Need for therapy is demonstrated by assessment that shows patient has reasonable expectation of being able to drive a vehicle after being treated under occupational therapy plan of care.

Y. Wheelchair management, including assessment, fitting, and/or training for patient who must utilize wheelchair for mobility when patient/caregiver has capacity and willingness to learn from instruction.

Z. Removal of devitalized tissue from wound(s), non-selective debridement whenever necrotic tissue is present in open wound (e.g., wet-to-moist dressing, enzymatic, abrasion, larval therapy), including topical application, wound assessment, and instruction for ongoing care.

AA. Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report for patient with neurologic, musculoskeletal, or pulmonary condition.

BB. Assistive technology assessment of suitability and benefits of acquiring any assistive technology device or equipment that will help restore, augment, or compensate for existing functional ability in patient (e.g., provision of large amounts of rehabilitative engineering).

CC. Orthotic(s) management and training, initial encounter for upper extremity(ies), lower extremity(ies), and/or trunk as documented by **ALL** of the following:

- Skilled therapy to assess and fit; and
- Instruct in use of orthotic.

DD. Prosthetic training, including preparation of stump, skin care, modification of prosthetic fit (revision to socket liner or stump sock), and initial mobility and functional activity training.

EE. Muscle and range of motion testing, on rare occasion to perform **thorough** range of motion or manual muscle test during course of treatment that is separate from evaluation/re-evaluation for patient with complicated condition (for example, patient with incomplete C5 quadriplegia at 6 months' post-injury may need specialized testing for rang of motion (ROM) or strength measurements to address specific deficits and goals).

FF. Application of casts, strapping, and splinting codes, as indicated by **1 or more** of the following:

- Cast application or strapping is replacement procedure used during or after period of follow-up care;
- Cast application or strapping is initial service performed without restorative treatment or procedure(s) to stabilize or protect fracture, injury, or dislocation and/or to afford comfort to patient.

GG. Splinting for clinical situation (e.g., fracture, sprain, dislocation) where temporary immobilization/fixation is required until there is further treatment disposition.

HH. Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), for treatment of benign paroxysmal positional vertigo when performed by physician, qualified non-physician provider, and therapist.

II. Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) to determine if abilities such as orientation, memory, and high-level language function have been compromised and to what extent by acute neurologic events such as traumatic brain injury (TBI) or cerebrovascular accident (CVA).

Outpatient physical and occupational therapy services **are considered not medically necessary** for **ANY** of the following:

1. Service related to recreational activity (such as golf, tennis, running, etc.).
2. To effect improvement or restoration of function where patient suffers transient and easily reversible loss or reduction in function that could reasonably be expected to improve spontaneously as patient gradually resumes normal activities.
3. Service that does not require professional skills of therapist to perform or supervise is not medically necessary, even if service is performed or supervised by therapist, physician, or NPP.
4. Service performed by personnel **not** authorized to provide outpatient therapy service, as indicated by **1 or more** of the following:
   A. Student;
   B. Aide;
   C. Athletic trainer;
   D. Exercise physiologist;
   E. Massage therapist;
   F. Recreation therapist;
   G. Kinesiotherapist;
   H. Low vision specialist;
   I. Lymphedema specialist;
   J. Pilates instructor;
   K. Rehabilitation technician;
   L. Life skills trainer.
5. Diathermy (i.e., microwave) for treatment of asthma, bronchitis, or any other pulmonary condition.
6. Iontophoresis for iontophoretic delivery of nonsteroidal anti-inflammatory drugs (NSAIDs) or corticosteroids when used for treatment of musculoskeletal disorders.
7. Contrast bath when service provided is hot and cold pack.
8. Ultrasound for **1 or more** of the following:
   A. Asthma, bronchitis, or any other pulmonary condition;
   B. Condition for which ultrasound can be applied by patient without need for therapist or other professional to administer, and/or for extended period of time (e.g., devices such as PainShield MD); or
   C. Wound.

9. More than one form of hydrotherapy during a visit.
10. Therapeutic exercise to promote overall fitness, flexibility, endurance (in absence of complicated patient condition), aerobic conditioning, or weight reduction.
11. Therapeutic exercise that does not require, or no longer require, skilled assessment and intervention of qualified professional/auxiliary personnel.
12. Exercise in water environment to promote overall fitness, flexibility, improved endurance, aerobic conditioning, or weight reduction.
13. Gait training, when patient's walking ability is not expected to improve.
14. Repetitive walk-strengthening exercise (such as for feeble patients or to increase endurance or gait distance).
15. Massage performed as isolated treatment.
16. Manual lymphatic drainage/complex decongestive therapy for **1 or more** of the following:
    A. Condition reversible by exercise or elevation of affected area;
    B. Dependent edema related to congestive heart failure or other cardiomyopathies;
    C. Patient who does not have physical and cognitive ability, or support system, to accomplish self-management in reasonable time; or
    D. Continuing treatment for patient noncompliant with program for self-management.
17. Supervision of previously taught exercise program or supervising patient who is exercising independently.
18. Supervision of patient exercising on machine or exercise equipment, in absence of delivery of skilled care.
19. Group therapy for **1 or more** of the following:
    A. Group directed by student, therapy aide, rehabilitation technician, nursing aide, recreational therapist, exercise physiologist, or athletic trainer;
    B. Routine (i.e., supportive) group that is part of maintenance program, nursing rehabilitation program, or recreational therapy program;
    C. Viewing videotape; listening to audiotape; or
    D. Group treatment that does not require unique skills of therapist.
20. Repetitious completion of therapeutic activity once taught and monitored.
21. General activity program, and all activities that are primarily social or diversional in nature.
22. Driving assessment performed only for purpose of disqualifying patient from driving.
23. Service considered non-covered for treatment of wound, as indicated by **1 or more** of the following:
    A. Ultrasound;
    B. Infrared and/or near-infrared light and/or heat, including monochromatic infrared energy;
    C. Low level laser treatment;
    D. Magnet therapy;
    E. Autologous blood-derived product for chronic non-healing wound;
    F. Routine dressing change.
24. Physical performance test or measurement for **1 or more** of the following:
    A. Performed and billed on routine basis (i.e., monthly or instead of billing re-evaluation); or
    B. Routinely performed on all patients treated.

25. Assistive technology assessment for routine seating and mobility system (e.g., manual/power wheelchair evaluations).
26. Orthotic(s) management and training service for **uncomplicated** condition that does not require unique skills of therapist, as indicated by **1 or more** of the following:
    A. Issuing off-the-shelf splint for foot drop or wrist drop;
    B. Issuing off-the-shelf foot or elbow cradle for routine pressure relief (these are not considered orthotics);
    C. Issuing "carrots" (i.e., cylindrical, cone-shaped forms) or towel roll for hand contractures for hygiene purposes; or
    D. Bed positioning (e.g., pillows, wedges, rolls, foot cradles to relieve potential pressure areas).
27. Prosthetic training assessment for upper and/or lower extremity(ies), as indicated by **1 or more** of the following:
    A. Device is newly issued;
    B. Device is reissued;
    C. Replaced after normal wear and no modifications are needed.
28. Muscle and range of motion testing for **1 or more** of the following:
    A. Performed on routine basis; or
    B. Routinely used for all patients (e.g., monthly or in place of billing for re-evaluation).
29. Miscellaneous service that is non-covered as skilled therapy service, as indicated by **1 or more** of the following:
    A. Iontophoresis, except as indicated for primary focal hyperhidrosis;
    B. Anodyne;
    C. Dry hydrotherapy massage (e.g., aqua massage, hydromassage, or water massage);
    D. Massage chair or roller bed;
    E. Interactive metronome therapy;
    F. Craniosacral therapy;
    G. Electromagnetic therapy, except as indicated for chronic wound;
    H. Constraint induced movement therapy;
    I. Work-hardening program;
    J. Skilled therapy intervention (e.g., ultrasound, electrical stimulation, soft tissue mobilization, and therapeutic exercise) for treatment of **1 or more** of the following pelvic floor dysfunctions (not including incontinence):
        - Pelvic floor congestion;
        - Pelvic floor pain not of spinal origin;
        - Hypersensitive clitoris;
        - Prostatitis;
        - Cystourethrocele;
        - Enterocele;
        - Rectocele;
            - Vulvodynia,
            - Vulvar vestibulitis syndrome;
    K. Frequency specific microcurrent;

L. Whole body periodic acceleration;
M. Light beam generator therapy.

Policy Guidelines

None.

Description

Physical therapy (PT) is the treatment of disease or injury using therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living, and pain relief. Treatment may include active and passive modalities using a variety of means and techniques based upon biomechanical and neurophysiological principles.

Physical therapy services include therapeutic interventions tailored to the specific needs of the patient. Such interventions include therapeutic exercise programs to increase strength and endurance, as well as application of various other modalities including, but not limited to, heat, cold, electrical stimulation, ultrasound, hydrotherapy, and massage or mobilization techniques. These services must be rendered under a written plan of care established by a physician or other qualified non-physician practitioner (e.g., physician assistant), and must be performed by a licensed physical therapist, or by assistive personnel under the supervision of a licensed physical therapist; if performed by assistive personnel, such services shall not exceed his or her education, training and/or licensure. To be considered medically necessary, these modalities must also be proven and accepted as effective and/or safe for the treatment of disease or injury.

Durable condition-specific benefit is:

- A measurable improvement in or restoration of a functional impairment that resulted from a specific disease, trauma, congenital anomaly, or therapeutic intervention; and
- Able to be sustained long-term without significant deterioration.

A few examples of measurable parameters include range of motion (ROM) measurements, wound measurements, distance the patient can ambulate, and amount of support the patient needs to ambulate.

A maintenance program consists of activities that preserve the patient's present level of function and prevents regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Supportive therapy also refers to therapy that is needed to maintain or sustain level of function.

Aquatic therapy is therapeutic PT exercises taking place in or on water, most likely in a swimming pool. This involves the therapist doing manipulation, mobilization or manual stretching and strengthening in the water instead of on land. This type of therapy may be useful following intra-articular and ligament reconstruction in the knee, as well as for walking reeducation, strengthening leg muscles, and enhancing joint range of motion. Aquatic therapy may also be a beneficial form of patient treatment for rheumatic disease.

Whirlpool bath is a therapeutic bath in which all or part of the body is exposed to forceful whirling currents of hot water. Whirlpool bath may be used for debridement of traumatic wounds, burns, pressure ulcers or surgical wounds and as an adjunct means to achieve joint mobility.

Contrast bath is immersion of a part of the body alternately in hot and cold water.

Hubbard tank is a tank in which a patient may be immersed for the purpose of permitting an individual to perform underwater exercise.

Hydrotherapy is the application of water, in any form, but usually externally, in the treatment of disease. Any of the above listed forms of water baths or therapy could be called hydrotherapy.

Occupational therapy (OT) is a form of rehabilitation therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual.

Occupational therapy involves cognitive, perceptual, safety, and judgment evaluations and training. These services emphasize useful and purposeful activities to improve neuromusculoskeletal functions and to provide training in activities of daily living (ADL). Activities of daily living include feeding, dressing, bathing, and other self-care activities. Other occupational therapy services include the design, fabrication, and use of orthoses, and guidance in the selection and use of adapted equipment.

Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) specific to outpatient physical and occupational therapy services. (1)

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	95851, 95852, 95992, 96125, 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97139, 97140, 97150, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97169, 97170, 97171, 97172, 97530, 97535, 97537, 97542, 97545, 97546, 97750, 97755, 97760, 97761, 97763, 97799, 98925, 98926, 98927, 98928, 98929
HCPCS Codes	G0151, G0152, G0157, G0158, G0159, G0160, G0281, G0283, G0295, G0329, S8990

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

Centers for Medicare and Medicaid Services

1. Local Coverage Determination (LCD) Outpatient Physical and Occupational Therapy Services. (L33631. Revision 15). Centers for Medicare and Medicaid Services. Available at: <https://www.cms.gov> (accessed September 12, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
01/01/2026	Document updated. Coverage criteria revised to be consistent with coverage guidance from the Centers for Medicare and Medicaid Services. Reference 1 updated; others removed.
12/15/2024	Document updated with literature review. Coverage unchanged. References 2 and 7 added, others removed.
03/15/2023	Reviewed. No changes.

07/15/2022	Document updated with literature review. Coverage unchanged. References 10-12 added, others removed.
06/15/2021	Reviewed. No changes.
07/01/2020	Document updated with literature review. Coverage unchanged. References 1, 5, and 8 updated.
07/01/2018	Document updated with literature review. The following changes were made to Coverage: 1) Removed "restore acute loss of" and replaced with "improve" in the following statement: "Is reasonably expected to improve function to an individual who suffers from functional impairment due to disease, trauma, congenital anomalies, or prior therapeutic intervention"; 2) Removed Montana, State Legislation mandates statement and replaced with *CAREFULLY CHECK STATE REGULATIONS AND/OR THE MEMBER CONTRACT*.
01/01/2017	Reviewed. No changes.
04/01/2015	Document updated with literature review. The following was added to Coverage: 1) Terminology was modified so that "qualified provider" either replaced "physician", or was added along with "physician"; 2) Physical or manipulative therapy performed for maintenance rather than restoration is considered not medically necessary; 3) Information was added to the NOTE (about qualified providers) regarding direct access to PT care without a physician's referral; 4) Language stating coverage of PT in water is allowed/not allowed was changed to may be considered medically necessary/not medically necessary; 5) Recertification requirements were clarified and "every 30 days" was removed; 6) Requirements for certification and recertification were revised to be "A certification request must include all required plan of care elements. Certifications will be valid for either the number of treatments, the number of weeks, or the number of calendar days, whichever is longest. In no case will a certification be granted for more than 90 calendar days from the first treatment day under that certified treatment plan. Proposed therapy beyond a certification requires formal recertification."
04/15/2014	Document updated with literature review. Coverage unchanged.
08/01/2011	Coverage revised. The following statements were added: OT services that may be considered medically necessary include treatments that are expected to result in significant functional improvement, and are for the purpose of enabling the patient to perform activities of daily living. OT services that consist of non-essential, self-help, or recreational tasks are considered not medically necessary, including training to facilitate reintegration into community and/or work environment (i.e., shopping, money management, educational and vocational activities, gardening, driving, etc.)
01/01/2010	CPT/HCPCS code(s) updated, medical policy unchanged

11/01/2009	Policy was edited to clarify that Occupational Therapy (OT) providers may also be providers of Physical Therapy Services, and that this policy does apply to OT providers. Policy title was revised to include OT.
04/01/2008	Policy reviewed without literature review; new review date only.
08/15/2006	BIT changes only
03/15/2006	Revised/updated entire document
10/01/2004	CPT/HCPCS code(s) updated, medical policy unchanged
01/01/2002	Revised/updated entire document. CPT/HCPCS code(s) updated, medical policy unchanged
06/01/2001	CPT/HCPCS code(s) updated, medical policy unchanged
05/01/2000	Revised/updated entire document
11/01/1999	CPT/HCPCS code(s) updated, medical policy unchanged
09/01/1999	CPT/HCPCS code(s) updated, medical policy unchanged
01/01/1998	Revised/updated entire document
05/01/1996	Revised/updated entire document
10/01/1994	Revised/updated entire document
09/01/1990	New Medical Document