Introduction

Physical therapy is a type of physical medicine and rehabilitation that treats disease, injury, or deformity using massage, heat, and exercise in place of drugs or surgery. It is done by physical therapists. Massage therapy may also be given by licensed massage therapists. Exercise and massage help make it easier for people to move, decrease pain, and aid in returning people to their daily activities. Each person is given an individualized treatment plan. This policy outlines when these services are may be covered.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Medical Necessity</th>
</tr>
</thead>
</table>
| Physical medicine and rehabilitation — physical therapy (PM&R – PT) | Physical medicine and rehabilitation — physical therapy (PM&R – PT), including medical massage therapy services — may be considered medically necessary when ALL of the following criteria are met:  
  • The patient has a documented condition causing physical functional impairment, or disability due to disease, illness, injury, surgery or physical congenital anomaly that interferes with activities of daily living (ADLs). (See Definition of Terms)  
  AND  
  • The patient has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time based on specific diagnosis-related treatment/therapy goals  
  AND  
  • Due to the physical condition of the patient, the complexity and sophistication of the therapy and the therapeutic modalities used, the judgment, knowledge, and skills of a qualified PM&R-PT or medical massage therapy provider are required.  
    o A qualified provider is one who is licensed where required and performs within the scope of licensure  
  AND  
  • PM&R-PT and/or medical massage therapy services provide specific, effective, and reasonable treatment for the member’s diagnosis and physical condition consistent with a detailed plan of care (see Documentation requirements).  
    o PM&R-PT and/or medical massage therapy services must be described using standard and generally accepted medical/physical/massage therapy/rehabilitation terminology. The terminology should include objective measurements and standardized tests for strength, motion, functional levels and pain.  
    o The plan should include training for self-management for the condition(s) under treatment.  
    o Services provided that are not part of a therapy plan of care, or are provided by unqualified staff are not covered. |
<p>| Medical massage therapy                                   | Medical massage therapy may be considered medically necessary                      |</p>
<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>necessary as the only therapeutic intervention when ALL of the above criteria for physical medicine and rehabilitation — physical therapy (PM&amp;R – PT) are met AND:</td>
<td>• The diagnosis-specific prescription, from the attending clinician with prescribing authority, stating the number of medical massage therapy visits is retained in the member’s massage therapy medical record. AND • The diagnosis-specific plan of care, approved by the attending clinician with prescribing authority, is retained in the member’s massage therapy medical record.</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation: Physical Therapy (PM&amp;R-PT) and medical massage therapy is considered <strong>not</strong> medically necessary when criteria are not met.</td>
<td></td>
</tr>
<tr>
<td>Home-based skilled rehabilitative physical and medical massage therapy</td>
<td>Home-based physical therapy (PM&amp;R-PT), including medical massage therapy services may be considered medically necessary when the patient is homebound and other medical necessity criteria detailed in this policy are met (see Definition of Terms).</td>
</tr>
<tr>
<td>Duplicate therapy</td>
<td>Duplicate therapy is considered <strong>not</strong> medically necessary.</td>
</tr>
<tr>
<td>• Duplicate therapy is when physical therapy (PT), occupational therapy (OT), and/or medical massage therapy provide the same treatment for the same diagnosis. Services provided concurrently by PT, OT, medical massage therapy may be covered if there are separate and distinct functional goals for different diagnoses.</td>
<td></td>
</tr>
<tr>
<td>Maintenance therapy programs</td>
<td>Maintenance therapy programs are considered <strong>not</strong> medically necessary (see Definition of Terms).</td>
</tr>
<tr>
<td>Non-skilled therapy</td>
<td>Treatment that does not generally require the skills of a qualified physical medicine and rehabilitation-physical therapy (PM&amp;R-PT) and/or medical massage therapy provider are considered <strong>not</strong> medically necessary (see Definition of Terms).</td>
</tr>
</tbody>
</table>
Documentation Requirements

The clinical impression, diagnosis and treatment care plan documented for the initial and the follow-up visits must clearly support the medical necessity of the rehabilitation therapy provided.

Documentation must be legible and include:

- A key for any symbols, abbreviations or codes that are used by the provider and/or staff
- Brief notations, check boxes, and codes/symbols for treatment are acceptable if the notations refer to a treatment modality that has been described in the current plan of care
- Initials of the provider of service and any staff/employees who provide services

Documentation of objective findings include the following information:

- A statement of the patient’s complaint
- Signs and symptoms of impairment or injury
- Signs or symptoms of the patient’s inability to perform activities of daily living (ADLs)

The treatment plan of care:

- Is patient-centered and appropriate for the symptoms, diagnosis and care of the condition
- Includes objectively measurable short and long-term goals for specific clinical and/or functional improvements in the patient’s condition with an estimated completion date
- Includes details of the specific modalities and procedures to be used in treatment
- Is approved by the referring physician (if applicable)

A re-evaluation of the patient’s progress is completed at each follow-up visit and includes documentation of:

- Objective physical findings of the patient’s current status
- The patient’s subjective response to treatment
- Measured clinical and/or functional improvement in the patient’s condition
- A review of the treatment plan of care along with progress toward the short and long-term goals for discharge from therapy
- Updates to the initial treatment plan of care with new goals that are appropriate to the patient’s condition
- Reporting to the referring clinician with prescribing authority (if applicable) about the therapy outcomes and recommendations for follow up
### CPT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97022</td>
<td>Application of a modality to 1 or more areas; whirlpool</td>
</tr>
<tr>
<td>97039</td>
<td>Unlisted modality (specify type and time if constant attendance)</td>
</tr>
<tr>
<td>97124</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)</td>
</tr>
<tr>
<td>97139</td>
<td>Unlisted therapeutic procedure (specify)</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes</td>
</tr>
</tbody>
</table>

### HCPCS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151</td>
<td>Services of a physical therapist in a home or health setting, each 15 minutes</td>
</tr>
<tr>
<td>S9131</td>
<td>Physical therapy, in the home, per diem</td>
</tr>
</tbody>
</table>

**Note:** CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

### Related Information

#### Definition of Terms

**Activities of daily living (ADL):** Self-care activities done daily within a member’s place of residence which include:

- Ambulating (walking)
- Dressing/bathing
- Eating
- Hygiene (grooming)
- Toileting
- Transferring (to/from bed or chair)

**Fluidized therapy – physical therapy (Fluidotherapy®):** A dry heat whirlpool using particles (sand-sized ground corn cobs) in a heated air stream. Fluidotherapy® treats acute or subacute...
traumatic or nontraumatic musculoskeletal disorders of the extremities as an alternative to other heat therapy modalities. This physical therapy service might be billed with CPT codes found in the Coding section of this policy with documentation of the therapy provided.

**Homebound/confined to home:** A member may be considered homebound if:

- Their medical condition restricts the ability to leave their place of residence (except with the aid of supportive devices such as wheelchairs and walkers, the use of special transportation, and/or the assistance of another person); or
- Leaving the home would require a taxing effort; or
- Leaving home is medically contraindicated.

Homebound status also applies to those members that require assistance when performing ADLs (e.g. transferring, walking or eating etc.).

A member confined to home may leave their place of residence for medical treatment such as chemotherapy.

Homebound status may be applied to members with compromised immune status or who are in such poor health that reverse isolation precautions are recommended by their providers to avoid exposure to infection(s). Examples of a poor resistance to disease may include but are not limited to:

- Premature infants, or
- Patients undergoing chemotherapy, or
- Patients with a chronic disease that has lowered their immune status.

**Note:** Homebound status is not determined by the lack of available transportation, or the inability to drive.

**Instrumental activities of daily living (IADLs):** Activities related to independent living that do not involve personal care activities.\(^1\) Activities that may not always be done on a daily basis include:

- Communication (using the telephone, computer or other communication devices)
- Housework/home maintenance
- Managing personal finances
- Managing medications
• Preparing meals
• Shopping
• Transportation (driving or using public transit)

**Maintenance program:** A maintenance therapy program consists of activities that preserve the patient’s present level of function and prevent regression of that function rather than provide immediate corrective benefit. Maintenance begins when the therapeutic goals of the Plan of Care have been achieved, or when no additional functional progress is apparent or expected to occur. This may apply to patients with chronic and stable conditions where skilled supervision is no longer required and clinical improvement is not expected. The specialized knowledge and judgment of a qualified provider may be required to establish a maintenance program; however, the continuation of PM&R-PT and/or medical massage therapy services to maintain a level of function are **not** covered.

Examples of maintenance therapy may include, but are not limited to:

• Additional PM&R-PT and/or medical massage therapy services when the patient’s chronic medical condition has reached maximum functional improvement

• PM&R-PT and/or massage therapy services that enhance performance beyond what is needed to accomplish routine functional tasks

• Passive stretching exercises that maintains range of motion and are performed by non-skilled personnel

• A general home exercise program that is not focused on the identified impairments or functional limitations.

**Non-skilled services:** Activities that maintain function and could be done safely and effectively by the patient or a non-medical person without the skills or supervision of a qualified provider.

Non-skilled Services may include but are not limited to:

• Activities that the patient performs without direct supervision of a qualified provider such as treadmill, stationary bike, or other aerobic activity for warm-up or general conditioning

• Modalities that the patient self-applies without direct supervision of a qualified provider, such as stretching/resistance exercises with a TheraBand™, traction, automobilization tables (Spinalator, Anatamotor, etc.) or Wobble chairs
• Passive range of motion (PROM) treatment, that is not related to restoration of a specific loss of function

• Treatment modalities that the patient self-applies without direct supervision of a qualified provider such as traction

• Unskilled repeated procedures that reinforce previously learned skills to maintain a level of function and/or prevent a decline in function

**Physical functional impairment:** A limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity (birth defect), pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.

**Plan of care:** The goal driven plan of care details the therapeutic interventions to guide health care professionals involved with the patient’s care. Goals are linked to the outcomes to be measured in order to assess and monitor the effectiveness of the therapy program (see **Documentation** section).

**Qualified provider:** One who is licensed where required and performs within the scope of licensure. Qualified providers of PM&R-PT services and medical massage therapy may include, but are not limited to:

• Advanced Registered Nurse Practitioner (ARNP) (ANP)

• Doctor of Chiropractic/Chiropractor (DC) (see **Related Policies**)

• Doctor of Osteopathy/Osteopathic Physician (DO)

• Doctor of Podiatric Medicine/Podiatrist (DPM) (limited by licensure requirements)

• Licensed massage practitioner/therapist (LMP, LMT) (subject to the member’s health plan benefit)

• Medical Doctors (MD)

• Naturopathic Physician (ND)

• Occupational Therapist (OT) (see **Related Policies**)

• Physical Therapist (PT)
**Note:** Qualified providers of PM&R-PT services and medical massage therapy must meet the definition in the member’s health benefit plan contract. Therapy services will not be covered when provided by athletic trainers, and other providers not recognized by the Health Plan. Please refer to the member’s benefit booklet or contact a customer service representative for specific language to determine coverage for the provider of service. (See Scope).

**Therapy visit:** A visit is defined as up to a one hour session of treatment and/or evaluation on any given day. These visits may include, but are not limited to the following:

- Chiropractic or osteopathic manipulative therapy
- Massage modalities including, but not limited to effleurage, petrissage, tapping and friction
- Patient and family education in home exercise programs
- Therapeutic exercise programs, including coordination and resistive exercises, to increase strength and endurance
- Traction, or mobilization techniques
- Various modalities including, but not limited to, fluidized therapy, thermotherapy, cryotherapy, and hydrotherapy

**Note:** The initial evaluation, as well as periodic reevaluations and assessments, may be performed as a separate service on the same day as the therapy visit described above.

**Benefit Application**

In some plans, the benefits available for Physical Medicine Rehabilitation – Physical Therapy and Medical Massage Therapy include a fixed number of treatment visits covered per year regardless of the patient’s condition or prescribed number of courses of therapy. When the maximum benefit is reached coverage will stop.

Some health plans may require physical medicine rehabilitation – physical therapy and medical massage therapy treatment plans obtain evaluation by eviCore healthcare to determine medical necessity based on their evidence-based clinical guidelines. Please contact Customer Service to check the member’s contract.
Plan of Care (POC) Update/Recertification

The plan of care must be updated as the patient’s condition changes and must be recertified by a physician or appropriate treating professional at least every 60 days.

Physical Medicine and Rehabilitation Therapy Types

**Physical Therapy**

Physical therapy (PT) is a form of rehabilitation with an established theoretical and scientific base and widespread clinical applications in the restoration, conservation, and promotion of optimal physical function.

**Medical Massage Therapy**

Medical massage, also called therapeutic massage, is outcome-based massage, using specific treatment modalities targeted to the functional problem(s) or diagnosis provided by the primary licensed clinician with prescribing authority.

Medical massage therapy or therapeutic massage may be provided by various qualified providers (see **Definition of Terms**).

Massage therapists, one type of medical massage provider, are required to be licensed by most states where the service is performed. The patient must be referred to the massage therapist by a licensed clinician with prescribing authority who writes a diagnosis-specific prescription for medical massage and approves the plan of care for a specific number of therapy visits.

Classification of Severity of Conditions

Severity is classified as mild, moderate and severe conditions. Severity is determined by various factors as noted in the following table.

**Table 1. Classification Criteria for Severity of Conditions**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Mild condition</th>
<th>Moderate condition</th>
<th>Severe condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mode of onset</td>
<td>Variable</td>
<td>Variable</td>
<td>Severe</td>
</tr>
</tbody>
</table>
### Evidence Review

This policy was originally created in 1997. Since that time the policy has been reviewed and updated using MEDLINE literature searches. The most recent update with literature review was through February 2017. Following is a summary of the key literature.

Physical therapy consists of treatment modalities prescribed to restore lost functional ability. Some of the therapeutic interventions include heat and cold, electrical stimulation, massage, therapeutic exercises, traction, gait training for ambulation and training in other functional activities. There are case studies found, however, few RCTs exist that address physical therapy modalities/manual medicine treatment as distinct from a comprehensive rehabilitation program.

In 2007 Taylor and colleagues summarized the benefits of therapeutic exercise based on a systematic review of the literature published from 2002-2005. The review extracted 36 studies that were classified into groups based on condition. The conditions were 6-cardiopulmonary, 6-neurology, 20-musculoskeletal (including: spinal n=7; peripheral n=9, arthritis n=4), and 4-other. Therapeutic exercise was found to be effective for patients with multiple sclerosis, osteoarthritis, subacute and chronic low back pain, chronic heart failure, coronary heart disease, chronic heart failure, coronary heart disease, chronic obstructive pulmonary disease (COPD), and intermittent...
claudication and after lumbar disc surgery. Outcomes measured the effect of therapeutic exercise in terms of physical impairment, and restriction or limitation to active participation in ADLs. The conclusions state that focused, patient-centered therapeutic exercise programs were effective; however, some of the trials were of poor quality.

In 2011, Cherkin and colleagues published results from a parallel-group randomized control trial (RCT) (NCT00371384) on the effects of two types of massage and usual care on chronic low back pain. Patients (n=401) with low back pain of no identified cause lasting at 3 months were randomly assigned to get relaxation massage (n=136), structural massage (n=132) or usual medical care (analgesic, anti-inflammatory, muscle relaxing drugs) without massage (n=133). Patients assigned to the massage groups received 1 hour of massage once a week for 10 weeks. The researchers measured patients' symptoms and ability to perform daily activities using the Roland Disability Questionnaire (RDQ) and symptom bothersomeness scores before starting the interventions and again after completing the 10 massage treatments, and then at 6 months and 1 year after starting massage therapy. The researchers found that patients who received massage had less pain and were able to perform daily activities better after 10 weeks than those who received usual care. The benefits of massage lasted for 6 months but were less clear at 1 year, when both pain and functional improvement were about equal in all 3 groups. The type of massage did not seem to make a difference. Symptoms and ability to perform activities improved about the same in the 2 massage groups. Study limitations were that the patients were not blinded to the treatment and the patients were mostly middle-aged, female and white which may limit applicability of the research findings to the general population.

In 2012, Perlman et. al. published the results of a RCT to determine the optimal “dose” of Swedish massage therapy for study participants identified with painful osteoarthritis (OA) of the knee. (NCT00970008) “The researchers defined optimal, practical dose as producing the greatest ratio of desired effect compared to costs in time, labor and convenience”. Participants (n=125) with OA of the knee were randomly assigned to one of four 8-week doses of a standardized regimen of Swedish massage therapy (30 or 60 minutes weekly or biweekly) or to a Usual Care control group. The Usual Care control group continued with their current treatment plan and did not receive massage therapy. The primary outcome measure was a change in the Western Ontario and McMaster Universities Arthritis Index (WOMAC-Global). Three researchers assessed the 125 enrolled participants’ pain, function, and joint flexibility. One hundred nineteen participants completed the 8-week trial and 115 completed the entire 24-week trial. Conclusion by the authors: Based on the convenience of a once-weekly protocol, cost savings, and consistency with a typical real world massage protocol, the 60-minute once weekly dose was determined to be optimal, potentially establishing a standard for future clinical trials.
In 2016, Nelson and Churilla published the results of a systematic review of randomized controlled trials of massage therapy for patients with arthritis. Their goal was to critically appraise and synthesize the current evidence regarding the effects of massage therapy as a stand-alone treatment on pain and functional outcomes among those with osteoarthritis or rheumatoid arthritis. Their review found seven randomized controlled trials representing 352 participants who satisfied the inclusion criteria. Their results found low- to moderate-quality evidence that massage therapy is superior to nonactive therapies in reducing pain and improving certain functional outcomes. They concluded that it is unclear whether massage therapy is more effective than other forms of treatment as an intervention for individuals with arthritis.¹⁴

**Practice Guidelines and Position Statements**

*American Physical Therapy Association (APTA)*

The APTA publishes positions and policies, the most recent revisions are available at [www.apta.org]({link}). It includes Guidelines for Physical Therapy Documentation:

“It is the position of the APTA that physical therapist examination, evaluation, diagnosis, and prognosis shall be documented, dated, and authenticated by the physical therapist that performs the service.” “Intervention provided by the physical therapist or physical therapist assistant, under direction and supervision of a physical therapist, is documented, dated, and authenticated by the physical therapist who performs the service or, when permissible by the law, the physical therapy assistant.”

**Medicare National Coverage**

“Part A covers medically necessary physical therapy services that are ordered by a physician under home health services if the patient is homebound. Part B helps pay for medically necessary outpatient physical therapy services that are ordered by a physician. Physical therapy services: include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached”. “Skilled therapy services may be necessary to:

- Improve a patient’s current condition,
- Maintain the patient’s current condition, or
• Prevent or slow further deterioration of the patient’s condition.6,9

References


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/05/97</td>
<td>Add to Therapy Section - New Policy</td>
</tr>
<tr>
<td>12/10/02</td>
<td>Replace Policy - Policy reviewed without literature review; new review date only.</td>
</tr>
<tr>
<td>05/13/03</td>
<td>Replace Policy - Policy reviewed; text deleted from Policy Guidelines; no criteria changes.</td>
</tr>
<tr>
<td>06/23/06</td>
<td>Update Scope and Disclaimer - No other changes.</td>
</tr>
<tr>
<td>07/10/07</td>
<td>New PR Policy - Policy updated with literature review; policy statement on maintenance programs added as not medically necessary. Benefit Application and codes updated. Policy changed from AR status to PR, replacing AR.8.03.02.</td>
</tr>
<tr>
<td>10/9/07</td>
<td>Cross References Updated - No other changes.</td>
</tr>
<tr>
<td>11/09/07</td>
<td>Reference added - No other changes.</td>
</tr>
<tr>
<td>05/13/08</td>
<td>Cross References Updated - No other changes.</td>
</tr>
<tr>
<td>08/12/08</td>
<td>Replace Policy - Policy updated with literature search. Policy statement updated to add the language “functional limitation or disability” under the medically necessary indication. Title updated to add “medicine and rehabilitation”. Codes and references added.</td>
</tr>
<tr>
<td>02/10/09</td>
<td>Replace Policy - Policy updated with literature search. Policy statement remains unchanged.</td>
</tr>
<tr>
<td>11/10/09</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>02/09/10</td>
<td>Replace Policy - Policy updated with literature search. No change to policy statement.</td>
</tr>
<tr>
<td>12/21/10</td>
<td>Cross Reference Update - No other changes.</td>
</tr>
<tr>
<td>02/08/11</td>
<td>Replace Policy - Policy updated with literature search. No change to policy statement. Policy Guidelines updated, along with the Benefit Application; no change to policy statements. Reference number one removed and replaced.</td>
</tr>
<tr>
<td>05/10/11</td>
<td>Replace Policy - The title has been updated to include “Massage Therapy.” Massage therapy has been incorporated to be part of the medically necessary policy statement when used in as part of PM&amp;R-PT. An additional policy statement has been added indicating that massage therapy is considered not medically necessary as a stand-alone procedure; a medically necessary policy statement has been added for home-based occupational therapy and the definition of “homebound” has been added to the Policy Guidelines section. Approved with 90-hold for notification; effective date is November 9, 2011.</td>
</tr>
<tr>
<td>11/07/11</td>
<td>Minor Update – Clarification to policy statement that massage therapy may be considered medically necessary as the sole procedure when criteria are met. Massage</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>02/27/12</td>
<td>Related Policies updated with 1.01.523.</td>
</tr>
<tr>
<td>10/26/12</td>
<td>Replace Policy. Added &quot;Medical&quot; to massage therapy in the title. Medical Necessity criteria moved to policy statement from policy guidelines section. Related policies revised with Chiropractic Services policy added. Revised wording of policy guidelines for clarity. Revised rationale section. References 5-8 added. Other references renumbered. Policy statement changed as noted, intent unchanged.</td>
</tr>
<tr>
<td>12/21/12</td>
<td>Minor update: add ARNPs and ANPs to the list of approved practitioners.</td>
</tr>
<tr>
<td>08/16/13</td>
<td>Replace policy. Rationale section updated based on literature review through June 2013; section reformatted for usability. Reference 2 added; others renumbered to match the reformatted rationale. Policy statement unchanged.</td>
</tr>
<tr>
<td>09/09/13</td>
<td>Replace policy. Removed policy requirement for submission of prescription and POC for massage therapy. Changed attending “physician” to attending “clinician with prescribing authority”. Policy guideline changed to say massage therapists are required to be licensed in most states instead of must be licensed in the state where service is performed. Changed “sessions” to “visits” to match wording in benefit booklets. Policy statement changed as noted. Update is subject to 90-day provider notification and will be effective 2/15/14.</td>
</tr>
<tr>
<td>01/21/14</td>
<td>Update Related Policies. Add 7.01.551.</td>
</tr>
<tr>
<td>03/17/14</td>
<td>Update Related Policies. Remove 1.01.523 as it was archived.</td>
</tr>
<tr>
<td>05/19/14</td>
<td>Update Related Policies. Remove 1.01.517 as it was archived.</td>
</tr>
<tr>
<td>09/03/14</td>
<td>Annual Review. Policy reviewed. Literature search through June 2014 did not prompt addition of new references. Policy statements unchanged.</td>
</tr>
<tr>
<td>08/11/15</td>
<td>Annual Review. IADLs added to Definition of Terms. Policy reviewed with a literature search through June, 2015. Reference 1, 9 added. Policy statements unchanged. ICD-9 procedure codes, HCPCS codes G0157, G0159 and S8950 removed; informational only. CPT code 97755 removed; no longer reviewed. Other information CPT codes also removed.</td>
</tr>
<tr>
<td>02/09/16</td>
<td>Annual Review. Policy reviewed. Policy statements unchanged.</td>
</tr>
<tr>
<td>07/01/16</td>
<td>Interim Update, approved June 14, 2016. Policy reviewed. Policy statements reformatted, intent is unchanged. Definitions in Benefit Application section moved to Definitions section in Policy Guidelines. Changed “sessions” to “visits” to match wording in benefit booklets. Added Classification of Severity of Conditions table. Added Benefit Application information that some member health plans may require review using eviCore guidelines. References added.</td>
</tr>
<tr>
<td>02/10/17</td>
<td>Policy moved to new format; no changes to policy statement.</td>
</tr>
<tr>
<td>05/01/17</td>
<td>Annual review, approved April 11, 2017. Policy reviewed; no change to policy statement. Reference 14 added.</td>
</tr>
</tbody>
</table>
Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2017 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.


Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.

Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Arabic):

يحرم هذا الإشعار معلومات هامة، قد يحرم هذا الإشعار معلومات مهمة، يحرم هذا الإشعار معلومات مهمة.

Premera Blue Cross is providing you with this notice to explain the important information contained in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.

Call 800-722-1471 (TTY: 800-842-5357).

中文 (Chinese):

本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Oromo (Cushite):


Français (French):


Deutsche (German):


Hmoob (Hmong):


Ilokano (Ilocano):

Daytoy a Pakdaa kat naglaon iti Napateg nga Impormasion. Daytoy a pakdaa mabalin nga adda kat naglaon iti napateg nga impormasion maiyanggep iti aplikasyonu yenno coverage babena Premera Blue Cross. Daytoy ket mabalin dagiti importante a pelta iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramideno nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalaineyo iti coverage ti salun-ayo yenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukdoyo a pagasasao nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):

This notification may contain important information. You have the right to obtain this information and assistance in your language of choice.

Polsko (Polish):
Informacja może zawierać ważne informacje. Jeżeli wykońana przez Ciebie inicjatywa obejmuje realizację określonych czynności w czasie określonym, przepis wykracza poza zakres obowiązujących przepisów.

Román (Romanian):