If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Oklahoma may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Physical Medicine and Rehabilitation Services

Policy Number: CPCP040

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: June 12, 2025

Plan Effective Date: September 22, 2025

Description

This policy provides general information on billing and claims processing for physical medicine and rehabilitation services. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal mandates or laws. Providers are urged to contact the Plan for specific coverage.

Definitions

Durable Medical Equipment - Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Home Setting- Includes the following- (1) The member's dwelling, such as a house, apartment, or other private living space; (2) A relative's home if the member resides there; (3) A place of residence used as a home or place of dwelling; (4) A home for the aged (not including SNF), i.e., retirement home or assisted living facility.

Modalities - Any physical agent applied to produce a therapeutic change to biological tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electrical energy.

> **Supervised:** Provider needs to watch over the application, though not necessarily at the patient's side. These are procedure/service based and units are always one (1).
>
> **Constant Attendance:** Provider must be with the patient at all times. These are time-based, one unit = 15 minutes.

Prescription/Written Order- A written prescription/order is a written communication from a treating provider that documents the need for a member to be provided with an item of durable medical equipment, prosthetics, orthotics, and supplies/DMEPOS and/or services.

Qualified Healthcare Professional/QHP - Is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within their scope of practice and independently reports that professional service.

Therapeutic Procedure - A manner of affecting change through the application of clinical skills and/or services that attempt to improve function.

Reimbursement Information

Providers are to document and bill appropriately for all services submitted. The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Coding Standards

- Proper coding is essential for correct reimbursement.
- Diagnosis and procedure coding with accurate corresponding date of service.

Diagnosis Codes

- New ICD10-CM diagnosis codes are updated bi-annually in April and October.
- Some diagnosis codes require a 7th digit to code to the highest specificity.
- Update diagnosis and coding for every new episode, including a re-exam or an examination for a 'new' problem. Providers should document any diagnosis coding change even if it is minor.
- Link the diagnosis to the service provided to support necessity and specificity.
    - **For example**: When performing manual therapy with manipulation, the diagnosis pointer code(s) should point to the specific diagnosed condition that supports the specific procedure billed. (Box 24E of the CMS-1500 claim form).

Physical Medicine & Rehabilitation Codes

Providers must submit the most appropriate code(s) for physical medicine and rehabilitation services as described under the "*Physical Medicine and Rehabilitation*" section in the most current publication of the CPT Code Book. Additionally, for physical medicine and rehabilitation services to be considered for coverage, the following conditions must be documented to support the usage of the CPT codes:

- The therapy must be of a skilled nature and require the services of a qualified healthcare professional.
- When services are delegated, documentation must include details of what was delegated and who performed the service(s).
- The services/therapy must not be maintenance in nature. Ongoing physical medicine treatment after a condition has stabilized or reached a clinical plateau (maximum medical improvement) does not qualify as necessary and would be considered "maintenance care."
- Services performed must achieve a specific diagnosis-related goal.
- There must always be a documented expectation that the member will, in fact, achieve reasonable improvement over a predictable period of time for the services to be eligible for reimbursement.
- Physical therapy for performance of athletic conditioning is not reimbursable by the Plan.

The following are commonly used physical medicine & rehabilitation therapeutic procedure codes. This is not an all-inclusive list.

CPT Code	Description	Additional Information
97110	Exercise Therapy 1 or more areas, each 15 minutes	Documentation must include: 1. The specific exercises performed. 2. The purpose of the exercises as related to function; and 3. The start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. These exercises should require the skills of a QHP. Supervising patients who are exercising independently is not a skilled service. The expected functional performance improvement should be discernable in the records.
97112	Muscle or nerve training 1 or more areas, each 15 minutes	Documentation must include: 1. The specific exercises/activities performed. 2. The purpose of the exercises/activities as related to function; and 3. The start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. These activities should require the skills of a QHP. Supervising patients who are performing activities independently is not a skilled service. The expected functional performance improvement should be discernable in the records. Appropriate use of CPT 97112 is for neuromuscular/NM diagnoses such as post-Cerebral Vascular Accident, Parkinson's Disease, cerebral palsy,

		Multiple Sclerosis, and other neuromuscular disorders. CPT 97112 is not appropriate for acute musculoskeletal problems and should not be used for spine or extremity stabilization. CPT 97112 is not appropriate for providers using Soft Tissue Mobilization techniques. Requires direct one-on-one patient contact throughout the procedure. Provider is required to maintain visual, verbal, and/or manual contact with the patient. Appropriate chiropractic manipulative treatment/CMT codes may be reported in addition to CPT code 97112 if performed in a spinal region outside of the manipulation.
97140	Body movement therapy 1 or more regions, each 15 minutes	Documentation must include: 1. The area being treated. 2. The therapy technique being used; and 3. The start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. The manual therapy performed should require the skills of a QHP. The expected functional performance improvement should be discernable in the records. CPT code 97140 should not be used interchangeably with CPT codes 98940-98943 or 97124. Appropriate CMT codes may be reported in addition to CPT code 97140 if performed in a body region outside of the manipulation.

		If a CMT is the only service performed, it is inappropriate to bill for multiple time-based codes, e.g., billing 97140 for several manual therapies. Note, a CMT CPT code may not be replaced with a different CPT code if the CMT was the actual service performed. It is a requirement to use the code that best describes the services rendered.
97530	Activity therapy Each 15 minutes	Documentation must include: 1. The area being treated. 2. The specific activity or technique being used; and 3. The start and stop times of the treatment or at a minimum, the direct one-on-one contact time spent on each individual activity. The activities should require the skills of a QHP. Supervising patients who are exercising independently is not a skilled service. The expected functional performance improvement should be discernable in the records.

Physical Therapy Evaluation

The following codes are associated with physical therapy evaluation services. Inclusion of a code below does not guarantee reimbursement.

CPT Code	Description
97161	Exam for physical therapy; Low complexity
97162	Exam for physical therapy; Moderate complexity
97163	Exam for physical therapy; High complexity
97164	Evaluation of physical therapy; Re-evaluation

Occupational Therapy Evaluation

The following codes are associated with occupational therapy evaluation services. Inclusion of a code below does not guarantee reimbursement.

CPT Code	Description
97165	Exam by occupational therapist; Low complexity
97166	Exam by occupational therapist; Moderate complexity
97167	Exam by occupational therapist; High complexity
97168	Exam by occupational therapist; Re-evaluation

Evaluation and Management (E/M) Services (CPT Codes: 99202-99499)

To bill for an e/m service, the complete CPT guidelines must be met for each service. The service must also be separately identifiable and distinct from any other service you perform on the patient that day. The Plan will not reimburse Physical and Occupational Therapists or Physical and Occupational Therapy Assistants for CPT evaluation and management codes 99202-99499.

Modifiers

For the purposes of this policy, a modifier should be appended to denote additional information about the service rendered.

CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care
96	Habilitative Services
97	Rehabilitative Services

Reporting Units for Timed Codes:

Some CPT codes for modalities are considered experimental, investigational and/or unproven/EIU and are not covered by the Plan. However, some modalities may be eligible for reimbursement, the following information will apply.

When multiple units of therapies or modalities are provided, the 8-minute rule must be followed when billing for these services. A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day and the procedure is performed for less than 8 minutes.

- The time reported should be the time actually spent in the delivery of the modality and/or therapeutic procedure. This means that pre- and post-delivery services should not be counted in determining the treatment time.

- The time that the member spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.
- All treatment time, including the beginning and ending time of the direct treatment, must be recorded in the member's medical record, along with the note describing the specific modality or procedure.
- Each minute of time may only be counted once. Any actual time the therapist uses to attend one-on-one to a member receiving a supervised modality cannot be counted for any other service provided by the therapist.

A unit of time is attained when the mid-point is passed.

- **For example**, for services billed in 15-minute units, providers should not report services performed for less than eight minutes.

For any single timed CPT code in the same day measured in 15-minute units, providers must use a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes.

Time intervals for 1 through 8 units are as follows:

Unit	Time
1	≥8 mins to 22 mins
2	≥23 mins to 37 mins
3	≥38 mins to 52 mins
4	≥53 mins to 67 mins
5	≥68 mins to 82 mins
6	≥83 mins to 97 mins
7	≥98 mins to 112 mins
8	≥113 mins to 127 mins

If billing for more than one modality/therapy, time should not be combined to report units. Each unit for the modality/therapy is reported separately for each code.

Durable Medical Equipment-DME

Prescription/Written Order for DME Supplies

A prescription/written order must be readily available if requested for DME rentals or purchase. The prescription/written order must be signed by the members

treating QHP. When a QHP completes and signs the prescription/written order, they are attesting that the information indicated on the form is correct and that the requested services are necessary and appropriate. Provider's prescription/written order for refills must be renewed at a minimum annually depending on the therapy, device, item, or service needs.

The prescription/written order for DME must include the following:

- Member's name, date of birth
- Diagnosis/Dx
- Description of the type of equipment/supplies ordered
- Ordering provider's rationale for requesting the equipment
- Date of prescription/order
- Date and duration of expected use
    - If appropriate add the length for the need, the frequency of usage, and the refill frequency.
- Quantity (if applicable)
- Ordering provider's name, address, and telephone number
- Ordering provider's legible signature and date

DME Components and Accessories

Repair, adjustment, or replacement of components and accessories of DME, as well as supplies and accessories necessary for effective functioning of covered DME items should be billed with the code which best describes the DME item.

- **For Example**, when ordering transcutaneous electrical nerve stimulations/TENS replacement products, utilize CPT code A4595 (electrical stimulator supplies) as opposed to billing the following CPT codes separately- A4556 (electrodes), A4557 (leads), A4558 (conductive paste or gel), and A4630 (replacement batteries).

Certain Customized DME

Customized DME or prosthetic and orthotic devices are specifically constructed to meet member's specific need. An invoice should be included with billing for any customized DME or prosthetic and orthotic device for which a procedure code or HCPCS code does not exist.

The following are examples of items that do **not** meet the requirement to be considered customized:

- An adjustable brace with Velcro closures
- A pull-on elastic brace
- A lightweight, high-strength wheelchair with padding added
- Add-ons or upgrades that are intended primarily for convenience beyond what is necessary to meet the member's needs.

The following additional criteria apply to custom-fitted and custom fabricated back braces.

- A custom-fitted back brace (a prefabricated back brace modified to a specific member) is considered necessary where there is a failure, contraindication, or intolerance to an unmodified, prefabricated (off the shelf) back brace.
- A custom-fitted back brace is considered necessary as the initial brace after a surgical stabilization of the spine following traumatic injury.
- A custom-fabricated back brace (individually constructed to fit a specific member from component materials) is considered necessary if there is a failure, contraindication, or intolerance to a custom-fitted back brace.
- Custom-fitted and custom-fabricated back braces are considered experimental and investigational when these criteria are not met.

Components of a Written Radiology Report

As a written record of the interpretive findings, the radiology report serves as an important part of the member's medical record and must contain the following items:

- Patient identification
- Location where studies were performed
- Study dates
- Types of studies
- Radiographic findings
- Diagnostic impressions; and
- Legible signature with professional qualifications included

Radiology reports may also include recommendations for follow-up studies and comments for further patient evaluation.

Additional Resources

Clinical Payment and Coding Policy

CPCP016 Chiropractic Care Services

CPCP023 Modifier Reference Policy

CPCP029 Medical Record Documentation

CPCP033 Telemedicine and Telehealth/Virtual Health Care Services Policy

CPCP036 Paravertebral Facet Injection Procedure Coding & Billing Policy

Medical Policy

DME101.000 DME Intro Policy

DME101.041 Pneumatic Traction and Spinal Unloading Devices

DME101.046 Traction Devices for Use in the Home.

THE801.004 Heat and Cold Therapy Devices

THE803.008 Non-Covered Physical Therapy Services

THE803.010 Physical Therapy (PT) and Occupational Therapy (OT) Services

THE803.021 Vertebral Axial Decompression

MED201.026 Surface Electric Stimulation

MED201.041 Interferential Current Stimulation

References

Healthcare Common Procedure Coding System (HCPCS)

Policy Update History

Approval Date	Description
03/15/2023	New Policy: Split from CPCP016 Chiropractic Care Services
01/12/2024	Annual Review
06/12/2025	Annual Review; Grammatical and formatting updates; Sections revised- Definitions: Home Setting updated; Coding Standards: Revised language; Diagnosis Codes: Additional month added; Physical Medicine & Rehabilitation Codes, bullets removed, table added. CPT code 97140: CPT code 98943 added to Additional Information column; Physical Therapy Evaluation section added; Occupational Therapy Evaluation section added; Modifiers 96 and 97 added to Modifiers table; Reporting Units for Timed Codes, bullets removed, and table added; Durable Medical Equipment section revised, new bullet for frequency added; Certain Customized DME revised, new bullet for convenience added; Additional Resources and References updated.