MEDICAL POLICY

Excellus
An independent licensee of the Blue Cross Blue Shield Association

Medical Policy Title	**Occupational Therapy (OT)**
Policy Number	**8.01.17**
Current Effective Date	August 21, 2025
Next Review Date	August 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Restorative or habilitative occupational therapy (OT) services are considered **medically appropriate** when determined by standardized assessment to meet the needs of individuals with **ANY** of the following indications:

A. Functional physical impairment due to disease;

B. Trauma/injury;

C. Congenital anomaly;

D. Prior therapeutic intervention(s).

In determining the medical necessity of OT services, consideration will be given to the degree/severity of limitation/deficit the impairment poses on the individual and whether the deficit(s) are expected to improve over a short period of time (generally up to two (2) months) with treatment.

Children exhibiting a severe delay or disorder identified by a functional impairment/deficit that adversely affects the child's performance, or a significant delay or disorder in one or more functional areas, as compared to accepted milestones for child development, which adversely affects the child's ability to learn. A significant delay or disorder in children is defined as:

- A 33% delay in one functional area or a 25% delay in each of two (2) areas; or
- If appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one (1) functional area or score of at least 1.5 standard deviations below the mean in each of two (2) functional areas.

II. Ongoing treatment is considered **medically necessary**, when significant improvement, as determined with reference to standardized assessment(s) completed during evaluation and repeated in follow-up session(s) and is demonstrated in objective measures.

III. OT services that are considered **not medically necessary** include, but are limited to **ANY** of the following:

A. Non-skilled services that do not generally require the skills of an OT:

1. Passive range of motion (PROM) treatment that is not related to restoration of a specific loss of function;

2. Treatments when given alone or to an individual who presents with no complications, including but not limited to:
    a. Infrared heat;
    b. Hubbard tank;
    c. Hot, cold or ice packs;
    d. Contrast, whirlpool or paraffin baths;
    e. Transcutaneous Electrical Nerve Stimulation (TENS);
3. Services that maintain function by using routine, repetitive, and reinforced procedures (e.g., daily feeding programs once the adaptive procedures are in place); conditioning; or land or water-based exercise programs;
4. Vasopneumatic compression; when used alone without the need for skilled monitoring of potential adverse signs and symptoms;
5. Crutch training.

B. Skilled OT services:
1. OT programs solely for sports and/or recreational purposes:
    a. Conditioning or strength training;
    b. Aquatic exercise programs such as water aerobics and water walking.
2. Gait analysis;
3. Sensory integration therapy (SIT);
4. Work-related or workers' compensation programs including but not limited to:
    a. Work evaluation;
    b. Work reconditioning;
    c. Work hardening programs;
    d. Sheltered work programs;
    e. Vocational training.

C. Maintenance programs.

IV. Constraint-induced movement therapy (CIMT), as a sole measure of therapy is considered **investigational** for all indications, including, but not limited to:
A. Cerebral palsy;
B. Congenital hemiplegia;
C. Stroke rehabilitation.

RELATED POLICIES

Corporate Medical Policy

2.01.13 Computerized Motion Diagnostic Imaging (CMDI)/Gait Analysis

7.01.11 Cosmetic and Reconstructive Procedures, which includes iontophoresis

8.01.12 Physical Therapy (PT), which includes dry needling

10.01.02 Chiropractic Care

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. Occupational therapy services should be provided by a licensed occupational therapist operating within their scope of practice. The therapist should address the functional needs of patients with physical impairments resulting from various causes, including disease, trauma, congenital anomalies, or prior therapeutic interventions. Treatment goals should be tailored to the patient's specific diagnosis, with an expectation of measurable improvement within a reasonable and predictable timeframe. The therapy provided should be specific, effective, and appropriate for the patient's diagnosis and physical condition.

II. OT documentation must contain a written plan of care, which should include:

   A. Diagnosis, including severity level of diagnosis;

   B. Specific statements of long- and short-term functional-based goals;

   C. Measurable objectives based on standardized outcome measures defined in evaluation and reassessed during follow-up sessions;

   D. A reasonable estimate of when the goals will be reached;

   E. The specific treatment techniques and/or activities to be used in treatment (skilled intervention);

   F. The frequency and duration of treatment; and

   G. Prior level of function (PLOF), prior treatment, and current level of function (CLOF).

III. Certain contracts only cover short-term OT services for a limited number of visits per condition, per lifetime, or per contract year. The visit limits do not apply when OT is for the treatment of a Mental Disorder (including autism spectrum disorder. Mental disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

IV. Coverage is not available for services provided by school districts, as stipulated in the child's (preschool ages 3-5 years and school age 5-21 years) Individualized Education Program (IEP), as the services are generally considered free care or a government program.

   A. When applicable, an IEP should be completed through the school district before a request for coverage is submitted to the Health Plan.

B. If a child is home-schooled, an assessment by the school district should be completed prior to submitting a request to the Health Plan for coverage. Requests for services for home-schooled children outside New York State will be reviewed on an individual basis in accordance with state regulations for the state in which the child lives.

C. Occupational therapy services denied by the school district, including summer services, and not covered in a child's IEP, will be reviewed by the Health Plan for medical necessity in accordance with member's subscriber contract.

D. If outpatient therapies requested are in addition to the school-based services noted in the IEP, or the provider does not feel that the child's needs are being met by the school-based services noted in the IEP, or when there is no IEP provided but it is documented that the child receives school-based services, documentation must include rationale supporting the medical necessity of the additional outpatient services beyond what the child is already receiving at school as noted in the IEP.

E. Interim summer programs are provided by school districts for children whose handicapping conditions are severe enough to warrant a structured learning environment of 12 months' duration in order to maintain developmental levels. For preschool children, summer instruction must be available for those whose disabilities are severe enough to warrant a structured learning environment of 12 months' duration to prevent substantial regression.

DESCRIPTION

Occupational Therapy (OT) is a form of rehabilitation therapy involving the treatment of individuals of all ages with functional deficits resulting from injury, disease, or birth. Occupational therapists assess all components of function (strength, range of motion, sensation, coordination, cognition, perception, vision, memory, judgment, safety, etc.) and work with the individual through the use of goal-directed, graded activity and exercise to improve skills. When this is not possible, adaptation of technique or equipment is utilized to improve function in areas of activities of daily living (ADL), which may include self-care (e.g., bathing, dressing, toileting, grooming, feeding), homemaking, money management, leisure, play, written communication, community re-entry, etc.

OT is a short-term therapy for which significant, measurable improvements are the expected result. Impairments range in severity from mild to severe and are classified according to their level of severity. A mild impairment is less than one standard deviation from normal, a moderate impairment is one to two standard deviations from normal, and a severe impairment is more than two standard deviations from normal.

Other related OT services include fabrication and/or selection and training in the use of orthoses, custom therapeutic garments, upper extremity prosthetics, and adaptive equipment/assistive technology. Use of superficial heat in preparation for functional activities (paraffin, hot packs, and fluid therapy) may be used.

Sensory Integration Therapy (SIT)

SIT is a form of OT that has been investigated as a method of treatment for autism, intellectually disable, or learning disabilities. Sensory integration therapy is aimed at improving the way the brain

processes and organizes sensations, as opposed to teaching higher-order skills.

Constraint-Induced Movement Therapy (CIMT)

CIMT is proposed as a method of therapy to help patients with neurological disorders (e.g., cerebral palsy, congenital hemiplegia, stroke) regain the use of dysfunctional limb(s). CIMT involves restraint of the unaffected limb and intensively engaging the affected limb in repetitive exercises, which results in the new neural pathways being generated in the brain.

Maintenance Programs

Maintenance programs consist of activities that preserve the patient's present level of function and prevent 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.

Work-Related Or Workers' Compensation Programs

Work-related or workers' compensation are for conditioning primarily for return to work and not treatment of a medical condition.

When OT services are needed to treat a medical or surgical condition in order for a patient to return to work, services are covered by the New York State Vocational and Educational Services for Individuals with Disabilities (VESID) Program.

SUPPORTIVE LITERATURE

García-Pérez et al (2024) conducted a prospective, randomized controlled clinical trial in 60 adults who have suffered a stroke and were discharged home and what the effectiveness of an early OT intervention programs (EOTIPS). Participants were assigned to the experimental group (n=30) were included in EOTIPS and were compared to a control group (n=30). Evaluations assessed quality of life (Stroke and Aphasia Quality of Life Scale [SAQOL-39]), functional independence (Modified Rankin Scale [mRS], Barthel Index [BI] and Stroke Impact Scale-16 [SIS-16]), perceptual-cognitive skills (Montreal Cognitive Assessment [MoCA]), upper limb function (Fugl Meyer Assessment [FMA]), mobility (Berg Balance Scale [BBS] and Timed Up & Go [TUG]), communication skills (Communicative Activity Log [CAL]) and mood disorders (Beck Depression Inventory–II [BDI-II] and Hamilton Anxiety Scale [HAMA]); they were completed within two weeks post-stroke and after three months follow-up. Statistical analysis included intent-to-treat analysis, considering all participants (dropouts as failures), and efficacy analysis, considering only end-of-treatment participants. Participants in the intervention group showed a significant better evolution in the main outcome measure of quality of life (SAQOL-39 p=.029), as well as for independence (mRSp=.004), perceptual-cognitive skills (MoCA p=.012) and symptoms of depression (BDI-II p=.011) compared to the control group. The authors stated that this study showed the effectiveness of EOTIPS in improving quality of life and leads to positive outcomes after stroke. This study did have limitations such as the occupational therapists were not blinded. The study also included patients with mild-moderate stroke sequelae, so results may not be valid for patients with moderate-severe sequalae, lastly rehabilitation session varied, and not all participants had a main caregiver that could help with rehab at home.

Sensory Integration Therapy (SIT)

There is insufficient evidence to permit conclusions regarding the effectiveness of SIT or whether SIT improves the net health outcome in children with autism and developmental impairments. Only one study was published for SIT in autistic children, and three studies were published for SIT in intellectually disabled children; the validity of all four studies is questionable. The evidence indicates that SIT does not improve the net health outcome in learning-disabled children when compared to alternative treatments or no treatment at all.

Randall et al (2024) conducted a two-arm randomized controlled trial to evaluate the clinical and cost-effectiveness of manualized SIT for autistic children with sensory processing difficulties. Recruitment, demographics, retention, adherence, and adverse effects are reported using descriptive statistics. Fidelity of intervention delivery is reported according to the intervention scoring manual. Qualitative interviews with therapists and carers were undertaken to explore the acceptability of the intervention and trial processes. Qualitative interviews with carers explored potential contamination. They recruited 138 children and carers (92% of those screened and 53.5% of those who expressed an interest) with 77.5% retained at 6 months and 69.9% at 12 months post-randomization. The intervention was delivered with structural and process fidelity with the majority (78.3%) receiving a 'sufficient dose' of intervention. However, there was consider- able individual variability in the receipt of sessions. Carers and therapists reported that trial processes were generally acceptable though logistical challenges such as appointment times, travel and COVID restrictions were frequent barriers to receiving the intervention. No adverse effects were reported. The authors found the process evaluation highly valuable in identifying contextual factors that could impact the effectiveness of this individualized intervention. They stated that rigorous evaluations of interventions for autistic children are important, especially given the limitations such as limited sample sizes and short-term follow-up as faced by previous research. A challenge that was noted is the variability of outcomes considered important by caregivers, as each autistic child has unique challenges. It is also important to consider the role of parents or other caregivers in facilitating access to these interventions as this may impact effectiveness.

Constraint-Induced Movement Therapy (CIMT)

There is insufficient evidence to permit conclusions regarding the effectiveness of CIMT for any indication. The majority of studies address the utilization of CIMT in either cerebral palsy, congenital hemiplegia, or stroke rehabilitation. Several studies, systematic reviews and meta-analyses have recently been published. They conclude that further rigorous, well-designed, randomized, controlled studies addressing CIMT are needed, to determine the efficacy of its use.

Reddy et al (2022) conducted a systematic review and meta-analysis aiming to delineate the effect of various lower extremity CIMT (LECIMT) protocols on gait speed, balance, and cardiovascular outcomes. For this study, clinical trials involving stroke populations in different stages of recovery, greater than 18 years old, and treated with LECIMT were considered, only ten studies were included. CIMT, when compared to controlled interventions, showed superior or similar effects. The effect of LECIMT on gait speed and balance were non-significant, with mean differences (SMDs) of 0.13 and 4.94 and at 95% confidence intervals (Cis) of (-0.18 – 0.44) and (-2.48 – 12.37), respectively. In this meta-analysis, the authors observed that despite the fact that several trials claimed the efficacy of LECIMT in improving lower-extremity functions, gait speed and balance did not demonstrate a

significant effect size favoring LECIMT. Therefore, CIMT treatment protocols should consider the patient's functional requirements, cardinal principles of CIMT, and cardiorespiratory parameters.

PROFESSIONAL GUIDELINE(S)

In June 2012, the American Academy of Pediatrics (AAP) issued a policy statement indicating that OT "with the use of sensory-based therapies may be acceptable as one of the components of a comprehensive treatment plan. However, parents should be informed that the amount of research regarding the effectiveness of sensory integration therapy is limited and inconclusive."

REGULATORY STATUS

Under the New York Insurance Law, all medical, major medical, and comprehensive-type contracts providing coverage physician services must provide coverage for the medically necessary screening, diagnosis, and treatment of autism spectrum disorders, when prescribed or ordered by a licensed physician or a licensed psychologist. Treatment includes services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, and/or social worker when the policy generally provides such coverage. Therapeutic treatment must include care that is deemed habilitative or non-restorative.

As of January 1, 2014, the Patient Protection and Affordable Care Act (PPACA) requires all health insurers to provide coverage for essential health benefits in the individual and small group markets, including habilitative services. Under PPACA, habilitative services are health care services that help a person keep, learn or improve skills and functioning for daily living and include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
97010	Application of a modality to 1 or more areas; hot or cold packs
97014	electrical stimulation (unattended)
97016	vasopneumatic devices (NMN when used without skilled monitoring)
97018	paraffin bath
97022	whirlpool

Code	Description
97024	diathermy (eg, microwave)
97026	infrared
97028	ultraviolet
97032	electrical stimulation (manual), each 15 minutes
97033	iontophoresis, each 15 minutes
97034	contrast baths, each 15 minutes
97035	ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.

Code	Description
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

Code	Description
97533 (NMN)	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537 (NMN)	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545 (NMN)	Work hardening/conditioning; initial two hours
97546 (NMN)	each additional hour
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity (ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity (ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

HCPCS Codes

Code	Description
G0129	Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)

Modifiers

Code	Description
96	Habilitative services
97	Rehabilitative services

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

American Academy of Pediatrics [Internet]. Sensory integration therapies for children with developmental and behavioral disorders. Policy statement. Pediatrics. 2012 Jun 1;129(6):1186-9. [accessed 2025 Jun 24]. Available from: http://pediatrics.aappublications.org/content/129/6/1186

Chamudot R, et al. Effectiveness of modified constraint-induced movement therapy compared with bimanual therapy home programs for infants with hemiplegia: a randomized controlled trial. Am J Occup Ther. 2018 Nov/Dec;72(6):7206205010p1-7206205010p9.

Hoare, et al. Constraint-induced movement therapy for upper extremities in people with stroke. Cochrane Database Syst Rev. 2018 Dec 12;(4):CD004149.

Dixon L, et al. Occupational therapy for patients with Parkinson's disease. Cochrane Database Syst Rev. 2007 Jul 18;(3):CD002813.

Durand E, et al. At-home and in-group delivery of constraint-induced movement therapy in children with hemiparesis: A systematic review. Ann Phys Rehabil Med. 2018 Jul;61(4):245-261.

García-Pérez P, et al. Early occupational therapy intervention post-stroke (EOTIPS): a randomized controlled trial. PLoS One. 2024 Aug 19;19(8):e0308800.

Gibson E, et al. Occupational therapy for cognitive impairment in stroke patients. Cochrane Library database of Systematic Reviews. 2022 Mar;3(3):1-236.

Handoll HH and Elliott J. Rehabilitation for distal radial fractures in adults. Cochrane Database Syst Rev. 2015 Sep 25;(9):CD003324.

Hoare BJ, et al. Constraint-induced movement therapy in children with unilateral cerebral palsy. Cochrane Database Syst Rev. 2019 Apr 1;(4):CD004149.

Hoffmann T, et al. Occupational therapy for cognitive impairment in stroke patients. Cochrane Database Syst Rev. 2010 Sep 8;(9):CD006430.

Huang HH, et al. Bound for success: a systematic review of constraint-induced movement therapy in children with cerebral palsy supports improved arm and hand use. Phys Ther. 2009 Nov;89(11):1126-41.

Landesman Ramey S, et al. Constraint-induced movement therapy for cerebral palsy: a randomized trial. Pediatrics. 2021 Nov;148(5):e2020033878.

Legg LA, et al. Occupational therapy for patients with problems in activities of daily living after stroke. Cochrane Database Syst Rev. 2017 Jul;(7):CD003585.

Myers SM, et al. Management of children with autism spectrum disorders. Pediatrics. 2007

Nov;120(5):1162-82.

Nasb M, et al. Constraint-induced movement therapy combined with botulinum toxin for post-stroke spasticity: a systematic review and meta-analysis. Cureus. 2021 Sep 1;13(9):e17645.

New York State Education Department. Regulations of the Commissioner of Education [Internet]. Part 200 – Students with disabilities. [accessed 2025 Jun 24]. Available from: https://www.nysed.gov/special-education/new-york-state-laws-and-regulations-related-special-education-and-students

Randell E, et al. Exploring critical intervention features and trial processes in the evaluation of sensory integration therapy for autistic children. Trials. 2024 Feb 17;25(1):131.

Reddy RS, et al. Impact of constraint-induced movement therapy (CIMT) on functional ambulation in stroke patients-a systematic review and meta-analysis. Int J Environ Res Public Health. 2022 Oct 6;19(19):12809.

Sakzewski L, et al. Systematic review and meta-analysis of therapeutic management of upper-limb dysfunction in children with congenital hemiplegia. Pediatrics. 2009 Jun;123(6):e1111-22.

Schaafsma FG, et al. Physical conditioning as part of a return-to-work strategy to reduce sickness absence for workers with back pain. Cochrane Database Syst Rev. 2013 Aug 30;(8):CD001822.

Steultjens EEMJ, et al. Occupational therapy for multiple sclerosis. Cochrane Database Syst Rev. 2003 Jul 21;(7): CD003608.

Steultjens EEMJ, et al. Occupational therapy for rheumatoid arthritis. Cochrane Database Syst Rev. 2004 Jan 26;(1): CD003114.

Stock R, et al. Early versus late-applied constraint-induced movement therapy: A multisite, randomized controlled trial with a 12-month follow-up. Physiother Res Int. 2018 Jan; 23(1).

United States Department of Education [Internet]. Individuals with Disabilities Education Act (IDEA). Public Law 94-142 [accessed 2025 Jun 24]. Available from: http://idea.ed.gov

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Outpatient Physical and Occupational Therapy Services (LCD L33631) [accessed 2025 Jun 25].

Outpatient Physical and Occupational Therapy Services (LCA Billing and Coding A56566) [accessed 2025 Jun 25].

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a

specific service, medical policy criteria apply to the benefit.

- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
11/19/99, 07/19/01, 08/22/02, 01/22/04, 04/28/05, 04/27/06, 02/22/07, 04/24/08, 04/23/09, 06/24/10, 06/24/11, 08/23/12, 08/22/13, 08/28/14, 08/27/15, 08/25/16, 08/25/17, 08/23/18, 06/27/19, 06/25/20, 06/24/21, 06/16/22, 08/17/23, 08/22/24, 08/21/25	
Date	**Summary of Changes**
08/21/25	• Annual review; policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
11/19/99	• Original effective date