

March 29, 2010

Matthew Fontana, M.D., Chief Medical Officer,  
Blue Cross and Blue Shield of New Mexico (BCBSNM)  
5701 Balloon Fiesta Pkwy NE  
Albuquerque, New Mexico 87113

Re: Coverage of CPT codes 97535 and 97537 as valid occupational therapy interventions

Dear Dr. Fontana:

This letter is in follow-up to earlier communication between the Health Care Service Corporation (HCSC) operating the Blue Cross and Blue Shield plans in Illinois, New Mexico, Oklahoma and Texas, and the American Occupational Therapy Association, Inc. (AOTA). In October, 2009 you spoke to AOTA's regulatory counsel about our concerns that HCSC does not recognize the following CPT codes that are the essence of occupational therapy practice. (HCSC: *Physical Therapy (PT) and Occupational Therapy (OT) Services*, Number: THE803.010)

**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 by provider, each 15 minutes**

97537 Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes

At that time, you requested that we provide you with such evidence as peer reviewed scientific research/literature on effectiveness, specialty society recommendations/position papers, and indications of industry standards related to the use of these codes. You offered to present our material to the Medical Policy Medical Director team to discuss possible policy changes.

The purpose of this letter is to substantiate our position that the use of activities of daily living and instrumental activities of daily living (ADL/ IADL) as part of the rehabilitation process are distinct, effective occupational therapy services that would be erroneously described by other CPT codes. These specific codes describe a specialized set of skilled activity-based interventions in which activities of daily living are integral to the procedures. In other words, occupational therapy practitioners use "occupations (activities) as a method of intervention implementation by engaging clients throughout the process in occupations that are therapeutically selected" (AOTA, 2008). "The profession's use of occupation as both means and end is unique application of the process" (Trombly, 1995).

In this letter and enclosed, we are submitting such evidence, including a summary of research articles, AOTA official documents, a selection of AOTA's Evidence-based Practice Guidelines that were recently accepted for inclusion by the National Guideline Clearinghouse™ (NGC), and an analysis of industry acceptance that support use of these CPT codes as unique descriptors of skilled services provided by occupational therapists.

## **Discussion of Evidence**

Occupational therapists' entry level education and training is based on the biological, physical, social, and behavioral sciences (AOTA, 2007b). However, occupational therapy (OT) differs from other types of rehabilitation in its core philosophy and approach. That is, incorporating meaningful "occupations" or activities that individuals must perform as part of their daily lives as part of the therapy process often leads to better physical and cognitive functional outcomes. Included in this package is the *Occupational Therapy Practice Framework: Domain and Process, 2<sup>nd</sup> Edition*, which explains the OT evaluation and intervention process as it relates to achieving functional improvement and participation in everyday life. You will see that the terminology used throughout this guide is closely linked to the International Classification of Functioning, Disability, and Health (ICF) that classifies not only body functions, structures, and impairments, but also activity, participation and environmental factors.

In an effort to document details of the comprehensive OT rehabilitation process for patients with Spinal Cord Injury in the United States, OT clinicians and researchers from 6 SCI rehabilitation centers developed a taxonomy to describe details of each OT session (Ozelie, et al. 2009). The taxonomy includes 26 OT activities. Of these, ADL skills training (with 7 sub-categories), home management and community reintegration are separately classified. Other categories within the taxonomy included communication, wheelchair mobility, bed mobility, transfers, balance, strengthening/endurance, stretching, equipment evaluation, and therapeutic activities.

According to the above taxonomy, "This all-encompassing category of therapeutic activities includes 10 OT treatments that do not fit easily into any of the other identified OT activities, including edema management, breathing exercise, visual/perceptual training, and cognitive retraining" (Ozelie, p.290). Clearly, the researchers and clinicians participating in this important project understand that ADL/IADL training and community reintegration are distinct interventions from therapeutic activities, and recognized the need to make this distinction clear when describing and reporting occupational therapy services. The project leaders also understood that ADL/IADL training are integral to the overall success of the rehabilitation process. We therefore assert that without the ability to submit the ADL and community reintegration codes, occupational therapist are forced to use other codes, primarily therapeutic activities (97530) to describe these skilled services. In addition to creating potential scope of practice and billing problems, limitations in reporting occupational performance codes are detrimental to accurate analysis of research data. One outcome we presently are seeing is a dampening effect on occupational therapists providing these interventions that are beneficial to the recovery and rehabilitation of patients.

The need for OT ADL/IADL interventions to be separately identified, reported and measured can be seen when evaluating articles, such as these measuring outcomes in patients with upper extremity (UE) injuries. In the first study, the Canadian Occupational Performance Measure (COPM), the Disability of Arm, Shoulder, and Hand (DASH), and the Short Form 36 (SF-36) were used to measure outcomes. Reported results show that “Clients with upper-extremity injury or surgery made strong, positive gains in functional measures following client-centered occupational therapy services” (Case-Smith, 2003). Another level one randomized controlled study found that individuals with acute and chronic hand injuries who were given activities that simulated ADL functions (opening and closing doors, using spoon, turning pages in a book, opening jars, etc.) had statistically significant higher levels of improvement in areas assessed than did those who participated in exercise-based treatment alone (Guzelkucuk, Duman, Taskaynatan & Dincer, 2007). These studies and others show that occupational therapy, based on use of functional performance (occupations), produces positive gains in clients with these types of injuries. As stated above, without the use of differentiating codes, analysis of different therapy interventions would not be possible.

Individuals with stroke are one of the major diagnostic categories receiving occupational therapy services. Occupational therapy practitioners are critical rehabilitation professionals for stroke survivors and may provide interventions in a variety of settings and at various lengths of time after the acute stroke. In a review of 15 studies, involving 895 participants, 11 (7 randomized controlled trials) found that “role participation and instrumental and basic activities of daily living performance improved significantly more with [occupational therapy] training than with the control conditions.” According to the authors, “The best evidence available in the occupational therapy literature, synthesized here, supports provision of opportunities for practice of client-chosen activities, preferably in a familiar context [emphasis added], and provision of necessary adaptations and training in the use of the adaptations” (Tromly & Ma, 2002.)

A Danish study focusing “on changes in quality of performance in ADL among people with moderate to severe disability following acquired brain injury pre- and post-intensive interdisciplinary rehabilitation”...suggests “that the possibilities for improvements in the quality of performance of ADLs do not depend only on (or so much on) the healing of the brain as they do on the relearning of daily life skills” (Waehrens and Fisher, 2007)

The concept of ADLs is sometimes misunderstood in relation to rehabilitation with children, as their “daily activities” and related terminology used to describe therapeutic interventions differ greatly from the terminology used for adults. However, children also respond well to therapy based on meaningful occupations. For example, in a study of children with burn injuries comparing therapy based on purposeful activity with rote exercise, it was found that “early in the rehabilitation process, the use of a play activity in comparison to rote exercise yielded better outcomes in terms of all four dependent measures” (Melchert-McKearnan, 2000).

In referencing this research and other articles, we are not suggesting that use of ADL and IADLs yields better outcomes in all situations. Use of therapeutic activities, exercise, and many other

procedures (techniques) may be the best clinical approach, and a combination of interventions often yields optimum outcomes. However, the therapy that is described by CPT codes 97535 and 97537 differs from other CPT codes, and occupational therapists should be allowed and encouraged to report these codes when they best describe the skilled therapy services provided.

### **Discussion of CPT Codes**

A form of the ADL code has been part of the CPT coding system for many years. In 1995, when the American Medical Association's (AMA) Health Care Professionals Advisory Committee (HCPAC) was formed, AOTA and APTA recommended changes to the therapy codes, which resulted in the renaming to *Physical Medicine and Rehabilitation (PM&R)*, a renumbering system, and terminology changes. In 1996, the CPT Editorial Panel approved a change which split the then ADL code into the existing ADL and Community Reintegration codes. In 2002, "training in the use of assistive technology" was added to the ADL code description, and later added to the community reintegration code when the assistive technology assessment code (97755) was added to CPT in 2004.

The American Medical Association's (AMA) publication *CPT Advisor* states that "These new codes (97535 and 97537) were added to distinguish components of treatment that have previously been reported under 97540, 97114 (deleted in *CPT 1995*) or HCPCS level 2 code H5300. These ...codes include (therapy) intervention in both physical and cognitive patient deficits that result from a wide range of physical and mental diagnoses and interfere with the patient's independent functioning in the specified (functional) areas" (*CPT Advisor*, September 1996). Individualized training in activities of daily living, including self care and safety, is central and essential occupational, therapeutic, intervention necessary for the achievement of a maximum level of functioning

An important consideration in the value of CPT codes is the differentiation among codes. As a condition for approving these codes, the CPT Editorial Panel agreed that 97535 and 97537 describe different therapy services than other CPT codes. The interventions (e.g., compensatory techniques, assistive technology training) exemplified in the descriptors of the codes are not found in any other codes. The training and skills of an occupational therapist are necessary in understanding the underlying body structures and body functions, as well as cognitive, environmental, and social factors, in determining the major clinical issues and barriers restrict a person's ability to perform specific activities and participate in previous life functions.

### **Industry standards**

Both the ADL (97535) and Community reintegration (97537) codes are recognized for payment by the **Medicare Program** and **State Medicaid Programs**. In addition, private payers, State Workers Compensation plans, and utilization management companies accept reporting of these codes as covered occupational therapy services.

For example, Triad Healthcare, accredited by URAC (formerly the Utilization Review Accreditation Commission) as a Health Utilization Management Company, contracts with a range of healthcare clients including HMO, PPO, POS, PFFS, indemnity and workers' compensation. This company "specializes in pain management for patients with low back pain, tendonitis, joint pain and hundreds of other painful musculoskeletal conditions." Triad uses an "evidence-based decision support system that facilitates data collection, care planning and peer consultation between Triad's specialty physician consultants...and physical medicine, pain medicine and surgical specialists," including occupational therapists. In its policy to establish criteria for the medical necessity of Activities of Daily Living (ADL) training and Self-Care Management, Triad states "Activities of daily living training and self-care management training may be considered **medically necessary** for patients who are impaired as a result of a developmental disability, injury, illness or surgery and require supervised training to help perform their normal activities of daily living which include but are not limited to bathing, grooming, dressing, eating, preparing meals, toileting, and transfers."

The following are a selection of relevant sections of other non-Medicare/Medicaid payer policies.

- Anthem UM Medical Guidelines ([www.anthem.com/medicalpolicies/guidelines/gl\\_pw\\_a051173.htm](http://www.anthem.com/medicalpolicies/guidelines/gl_pw_a051173.htm))
- AETNA Clinical Policy Bulletin: Occupational Therapy Services Number: 0250 ([http://www.aetna.com/cpb/medical/data/200\\_299/0250.html](http://www.aetna.com/cpb/medical/data/200_299/0250.html))
- CIGNA MEDICAL COVERAGE POLICY – Occupational Therapy ([http://www.cigna.ca/customer\\_care/healthcare\\_professional/coverage\\_positions/medical/mm\\_0232\\_coveragepositioncriteria\\_occupational\\_therapy\\_outpatient.pdf](http://www.cigna.ca/customer_care/healthcare_professional/coverage_positions/medical/mm_0232_coveragepositioncriteria_occupational_therapy_outpatient.pdf))
- US DOL Office of Workers' Compensation Programs (OWCP) (<http://www.dol.gov/owcp/regs/feeschedule/fee/accept09.htm>)
- Texas Workers' Compensation ([www.texmed.org/Template.aspx?id=6611](http://www.texmed.org/Template.aspx?id=6611))
- Illinois Workers' Compensation ([HTTP://iwcc.ingenixonline.com/download.asp](http://iwcc.ingenixonline.com/download.asp))

AOTA requests that BCBS reinstate the ADL and community reintegration codes (97535, 97537) as covered occupational therapy services, recognizing the intent of these codes in describing skilled therapy services that are distinct from other CPT PM&R codes. Evidence-based literature not only makes a distinction among these "occupation-based" services and other types of commonly reported CPT codes, but also supports positive outcomes when they are provided. Additionally, researchers use code-related information in investigating and describing differing therapy techniques in studies designed to yield "best evidence."

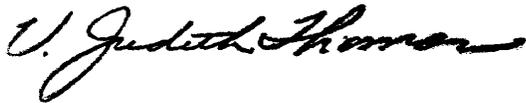
ADL and IADL/community reintegration training, as coded by 97535 and 97537, are widely accepted by researchers, payers, and healthcare professional organizations. As explained above, AMA documents support the validity of these interventions and codes as skilled PM&R services. AOTA's official documents and Practice Guidelines consistently differentiate these codes from other therapeutic procedures.

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The ability to develop patient goals and clinical interventions based on individual client performance and participation needs is a unique focus of occupational therapy. Restrictive policies that limit code submission further blur distinctions among therapy disciplines, skew research data, and create confusion for clients and claims reviewers, often artificially limiting access to needed care.

We look forward to your review of our request. Please let me know if I can provide any additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "V. Judith Thomas". The signature is fluid and cursive, with the first letter "V" being particularly large and stylized.

V. Judith Thomas, Senior Policy Manager

CC: **Kim Reed M.D.**, Senior Medical Director Blue Cross Blue Shield of Illinois  
**Allan J. Chernov M.D.**, Medical Director, Health Care Quality and Policy,  
Blue Cross and Blue Shield of TX  
**Charles Knife Chief M.D.**, Medical Director, Blue Cross and Blue Shield of OK

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