'ohana health plan

Clinical Policy: Aquatic Therapy

Reference Number: HI.CP.MP.500
Date of Last Revision: 08/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for aquatic therapy.

Policy/Criteria

I. It is the policy of Ohana Health Plan that aquatic therapy is **medically necessary** when all of the following criteria are met:

A. Service is performed under direct supervision of a licensed physical therapist with a physician's order;
B. The therapeutic interventions rendered are directly related to a written treatment regimen that includes goals approved and signed by the physician;
C. The member must have impairments, functional limitations or disabilities that can be minimized or eliminated with aquatic therapy;
D. The member must be able to benefit from the unique properties of water (i.e., buoyancy, hydrodynamics, and hydrostatic pressure);
E. A member selected for aquatic therapy must be unable to safely participate in a physical therapy program that is totally land based due to weight bearing restrictions, severe weakness, or other considerations;
F. The documentation must support the necessity of this intervention;
G. The aquatic therapy rendered must require the skills of a physical therapist;
H. A qualified therapist is physically present and actively involved in treatment;
I. Aquatic therapy services rendered are considered acceptable standards of medical practice for the member's condition.

II. It is the policy of Ohana Health Plan that current evidence does not support the use of aquatic therapy in any circumstance or indication not mentioned above.

Background

Aquatic therapy is an active therapeutic intervention that takes place in water. The aquatic environment provides buoyancy, increased resistance (e.g., viscosity) and warmth. The advantage of buoyancy is direct: when a person enters the water, there is an immediate reduction in the effect of gravity on the body. The advantage of viscosity of water is indirect: when the person moves through the water, resistance is felt. This is also referred to as accommodating resistance because it matches the individual's applied force or effort. Because the resistance of the water equals the force exerted, the likelihood of exacerbation or re-injury is reduced dramatically. Advocates of aquatic therapy have proposed that water allows ease of active movement, trunk stabilization, relaxation of spastic muscles, improved circulation, strengthening and functional activity training.[2] According to a study in 2007, a six-week aquatic physical therapy program resulted in significantly less pain and increased physical function, strength, and quality of life for participants with hip and knee arthritis.[1]Additionally, the warmth of the water

experienced during therapy aids in muscle relaxation and increases blood flow to injured areas, which is often especially therapeutic to patients with muscle spasms, back pain and fibromyalgia.[3]

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; Aquatic Therapy with therapeutic exercises

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		09/11
Annual review, no changes		06/18
Annual review, no changes		06/19
Annual review, no changes		04/20
Transitioned policy to new state specific template and sent to market for ownership, Policy number changed from HS-189 to HI.CP.MP.500	09/20	
Policy template updated-sent to market for ownership.	08/23	

References
1. Alzner S, Isaac Z. Joint protection program for the lower limb. UpToDate. www.uptodate.com. Updated January 19, 2022. Accessed August 16, 2023.
2. Peng MS, Wang R, Wang YZ, et al. Efficacy of Therapeutic Aquatic Exercise vs Physical Therapy Modalities for Patients With Chronic Low Back Pain: A Randomized Clinical Trial. *JAMA Netw Open*. 2022;5(1):e2142069. Published 2022 Jan 4. doi:10.1001/jamanetworkopen.2021.42069
3. Inverarity L, Campedelli L. The benefits of aquatic therapy. Verywell health. https://www.verywellhealth.com/aquatic-therapy-2696592. Updated October 28, 2022. Accessed August 16, 2023.

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence.

Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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