KAISER PERMANENTE® Mid-Atlantic States	**Aquatic Therapy** **Medical Coverage Policy**

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- Review of the appropriate government requirements, e.g., Federal brochure, Medicare Coverage Database or Maryland Medicaid and Virginia Medicaid coverage publications for general physical therapy is recommended.
- For Medicare members, please refer to CMS guidelines through the Medicare Coverage Database.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

I. Specialty: Physical Therapy; Rehabilitation

II. Procedure/Service: Aquatic Therapy (AT)

III. Clinical Indications for Referral

A. Initial aquatic therapy is medically necessary when ALL the following criteria are met:

1. When diagnosis includes **1 or more** of the following:
   a. Ankylosing spondylitis;
   b. Fibromyalgia;
   c. Knee Osteoarthritis; Hip Osteoarthritis *or*
   d. Rheumatoid arthritis

2. A physical therapy evaluation of the patient to perform land-based physical therapy exercises effectively to treat the condition or increase function prior to referral to aquatic therapy has been done and aquatic PT is recommended to get the patient to the point that they can participate in a land-based PT program.

3. Goals of the therapy have been identified and include **1 or more** of the following:
   a. Decreased pain;
   b. Improvement in cardiorespiratory fitness;
   c. Increased in functional ability;
   d. Increased in strength and range of motion; *or*
   e. Improvement in quality of life

4. Recent change in clinical status as indicated by **1 or more** of the following:
   a. Post hospitalization for comorbid condition;
   b. Recent diagnosis;
   c. Recent functional decline or post-acute exacerbation; *or*

d. Recent healed surgery

5. Absence of acute systemic disease exacerbation or untreated arthritis; ***and***
6. Absence of open wounds, uncontrolled seizures, or incontinence.

B. Extended aquatic therapy is medically necessary when ALL the following criteria are present:

1. Functional progress has been made during the initial therapy;
2. The goals of therapy have not yet been met and skilled services are still needed;
3. Ongoing active participation of the patient in treatment sessions and adherence to home program and recommendations; *and*
4. An expectation of attainable anticipated improvement in reasonable and generally predictable period.

IV. Exclusions

Clinical evidence does not support the use of aqua therapy for other uses, except those listed in section III of the policy. AT is not considered medically necessary for the following:

1. Children with developmental disabilities;
2. Chronic low back pain and pregnancy-related low back pain;
3. Neurologic or musculoskeletal pain;
4. Nondegenerative lower extremity injuries (e.g., ligament sprain, anterior cruciate ligament reconstruction);
5. Parkinson disease;
6. Stroke; *or*
7. Total knee arthroplasty

V. Limitations/Restrictions

A. Provision of aqua therapy are **non-covered** for the following:

1. Aqua therapy which duplicates other land-based rehabilitation services;
2. Aqua therapy used for ulcer debridement;
3. Water exercises to promote overall fitness, endurance, flexibility, aerobic conditioning, weight reduction or for maintenance purposes such as adapted aquatics or aquatic fitness;
4. Situations when the therapeutic exercise is not performed in the water environment; *or*
5. Employing aquatic therapy (CPT 97113) and hydrotherapy (CPT code 97022 and 97036) during the same treatment session.
6. Aquatic therapy is only covered when there is an individual therapist working with an individual patient. Group aquatic therapy will not be covered.

B. Limitations

1. Coverage of aquatic therapy is limited to aquatic therapist who provides the therapeutic procedure and subject to limitations according to member's group plan coverage. The use of pool and aquatic exercise programs are not covered.

2. The provision of aquatic therapy delivered in an AT pool must be operated and maintained in accordance with local and/or state health department regulations.

VI. Definition

1. Aqua Physical Therapy – is a one-to-one therapeutic procedure to improve physical function using active exercises in heated water by a licensed therapist, who is educated to meet the practice standards to perform aquatic therapeutic exercises, in accordance with the therapist's respective scope of practice and state law.

2. Therapeutic procedure – is a manner to effect change to improve physical function through application of clinical skills/and or services by a physician or therapist who have direct (one-on-one) patient contact and typically requires patient participation.

3. Therapeutic modality – an application of any physical agent to produce therapeutic changes to biologic tissue such as thermal, light, acoustic, mechanical, or electrical energy including but not limited to, hydrotherapy & whirlpool for wound care.

4. Hydrotherapy or water therapy is a passive modality through water (hot, cold, steam or ice) to elicit passive transmission of heat, cold, chemicals, friction, pressure or a combination through immersion of the body or body part(s).

5. Aquatic Fitness – a non-therapeutic modality or mode of water exercise performed in a face-out, vertical position in various depths of water, with the intent to improve physical and/or mental health. May include walking, jogging, exercises in a shallow or deep end of pool etc.

6. Adapted Aquatics – a non-therapeutic modality "learn to swim" program for individuals with disabilities.

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Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC*	Date of Implementation
08/29/2018	08/29/2018
09/26/2018	09/26/2018
09/26/2019	09/26/2019
09/24/2020	09/24/2020
09/27/2021	09/27/2021
08/31/2022	08/31/2022
07/25/2023	07/25/2023
06/25/2024	06/25/2024

*****The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.