Molina Clinical Policy
Occupational Therapy
Policy No. 409

Last Approval: 04/08/2026
Next Review Due By: April 2027

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

The American Occupational Therapy Association defines the practice of occupational therapy (OT) "as the therapeutic use of everyday life occupations with persons, groups, or populations…for the purpose of enhancing or enabling participation." Participation includes roles and situations in home, school, workplace, community, and other settings. The nature of therapy can be restorative/rehabilitative or maintenance oriented. Restorative/rehabilitative therapy is carried out with the purpose of reversing, wholly or partially, a previous loss of function. Maintenance therapy is carried out with the purpose of maintaining or slowing deterioration (Casto et al. 2022).

Occupational Therapists utilize clinical history, observation, interview, standardized testing, and assessment of activities of daily living, work skills, and leisure skills to characterize individuals with impairments, functional limitations, and disabilities. The results of these assessments are used to identify structural impairments and functional limitations and to design an individualized plan of treatment to assist in improving or restoring function. Services must be performed by or under the supervision of a qualified therapist, defined as an individual who is licensed and meets the practice requirements in the state where they are practicing.

While the skills of a qualified Occupational Therapist are required to evaluate the patient's level of function and develop a plan of care, implementation of the plan may also be conducted by a qualified Occupational Therapy Assistant functioning under the general supervision of the qualified Occupational Therapist. Some services must be provided by a licensed therapist, not by an assistant, such as a) making clinical judgements or decisions, b) developing, managing, or furnishing skilled maintenance programs, and c) supervising other clinicians or taking responsibility for the service rendered (CMS 2024, 2023).

State Resources

Early intervention is the process of providing services, education and support to young children who are deemed to have an established condition, those who are evaluated and deemed to have a diagnosed physical or mental condition (with a high probability of resulting in a developmental delay), an existing delay or a child who is at-risk of developing a delay or special need that may affect their development or impede their education. Early Intervention Programs are typically a first option for children who qualify and are up to age 3 years. Each state has special programs available for education and related services. The purpose of early intervention is to lessen the effects of the disability or delay. Services are designed to identify and meet a child's needs in five developmental areas: physical, cognitive, communication, social or emotional, and adaptive. An early intervention program is available within each State (refer to State-specific criteria).

COVERAGE POLICY

Please review individual State and Federal mandates and applicable health plan regulations before applying the criteria below. Please refer to requirements, criteria, and guidance from the State in which the Member is receiving treatment as the State's documents will supersede this Molina Clinical Policy.

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Initial Occupational Therapy Criteria

Occupational Therapy (OT) may be **considered medically necessary** when ALL the following are met:

1. Significant improvement is expected within a reasonable time, or it is necessary to develop and implement a maintenance program as evidenced by ONE of the following:
   a. There is a reasonable expectation that the Member's condition will significantly improve in a reasonable, predictable time because of the anticipated therapy services
   b. Anticipated therapy services are needed to implement a safe and effective maintenance program to be performed by the Member without ongoing skilled therapy services; services must be proposed for the treatment of a specific illness or injury

2. Therapy is ordered by a qualified Provider and performed by a licensed/certified OT Provider under applicable laws of the State where therapy is being provided

3. Therapy is performed for conditions related to a defect, developmental delay (i.e., child is not developing and/or achieving skills according to the expected time), functional impairment (i.e., a direct and measurable reduction in physical performance of an organ or body part) or pain as evidenced by supporting documentation recorded in medical records submitted for review

4. ALL the following documentation is provided:
   a. Diagnosis of the indicated disorder
   b. Date of onset or exacerbation of the indicated disorder
   c. Goals, both long-term and short-term, that are specific, quantitative, and objective
   d. An acceptable estimate of time of when the Member is expected to achieve therapeutic goals
   e. An OT evaluation
   f. Frequency and duration of treatment
   g. Prognosis for rehabilitation or habilitation
   h. Exact treatment techniques and/or exercises to be used in treatment

Additional Information

Providers of OT services shall possess applicable training, credentialing, licensure, and certification as determined by the State in which they are providing services. This includes modalities using physical agents that are applied to produce therapeutic changes to biologic tissue, including (but not limited to) thermal, acoustic, light, mechanical, or electric energy. Modalities can be supervised (not requiring direct one-on-one Provider / Member contact) or require constant attendance (requiring direct one-on-one Provider / Member contact).

Modalities where supervision is appropriate include, but are not limited to:

- Hot or cold packs
- Mechanical traction
- Vasopneumatic devices
- Whirlpool
- Paraffin bath
- Diathermy

Modalities requiring constant attendance include, but are not limited to:

- Contrast baths
- Ultrasound
- Electrical stimulation
- Iontophoresis

Continuation of Therapy

Continued therapy may be medically necessary when it is likely to allow the Member to restore a significant level of function within a reasonable and definable time and outcomes resulting from therapy cannot reasonably be achieved by continuing a home exercise program alone. Continued therapy may be **considered medically necessary** when ALL the following are met:

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1. Member has made functional progress during initial therapy
2. Therapy goals have not been met
3. Member is participating actively in treatment sessions
4. Member is compliant with the plan of care

Reevaluations

Reevaluations are distinct from routine therapy assessments. Routine therapy assessments are completed each session pre- and post-therapy to document the Member's progress towards goals. Reevaluations should include objective information not included in the routine documentation of therapy assessments. A reevaluation is NOT a routine, recurring service. Do not bill for routine reevaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report. Reevaluation codes are untimed and billable as one unit.

Reevaluations are a more comprehensive assessment that must be completed by a licensed therapist and include components of an initial evaluation, such as:

1. Date of last therapy evaluation
2. Number of therapy visits authorized, and number of therapy visits attended
3. Compliance to therapy program
4. Description of the Member's current deficits and their severity documented using objective data
5. Identifying the appropriate intervention(s) for new or ongoing goal achievement.
6. Revision in the Member's plan of care as indicated

Indications for a reevaluation include at least ONE of the following:

1. New clinical findings or diagnoses
2. A significant change in the patient's condition, such as hospitalization
3. Failure to respond to the therapeutic interventions outlined in the plan of care

Discharge and Discontinuation of Therapy

A Member may be discharged from OT services when the anticipated goals or expected outcomes have been achieved. Services may be discontinued when the Member cannot continue to progress toward goals OR if the Member no longer benefits significantly from OT services. Discontinuation of therapy is appropriate when ANY of the following are met:

1. Reasonable goals have been met and member or caregiver is independent with home therapy program
2. A functional plateau has been reached as evidenced by lack of improvement in function or symptoms for the last three (3) visits
3. Member's condition is not expected to improve significantly with further therapy as evidenced by ONE of the following:
    a. In the case of acute illness or injury, prior level of function or maximal functional ability has been achieved
    b. In the case of chronic condition, maximal functional ability has been achieved
    c. Member is unable or unwilling to participate in the therapy program
    d. Member is unable or unwilling to participate in a home exercise program

Limitations and Exclusions

All other requests for treatment that do not meet the above criteria are considered **not medically necessary** OR **experimental, investigational, and unproven.** This includes ALL the following:

1. Member's condition is not expected to improve (or has not improved) with therapy
2. Improvement of function could reasonably be expected as the Member slowly resumes normal activities, without the aid of therapy services. Examples include: an individual who suffered a temporary loss or reduction in function that is likely reversible and expected to recover as they resume normal activities OR an individual who did not have difficulty functioning and develops temporary weakness due to bed rest following surgery
3. Services that do not require the skills of a licensed or certified OT provider such as:
    a. Activities that benefit an individual overall such as: general exercises (e.g., basic aerobic, strength, flexibility, or aquatic programs) to promote overall fitness/conditioning; services that focus on enhancing athletic or recreational sports; massages and whirlpools for the purposes of relaxation; and public education classes

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   b. Repetitive gait or other activities that can be practiced individually and self-administered or that require routine supervision (not the skills of an OT provider) as well as home exercise programs to continue therapy
4. Insufficient documentation to objectively verify subjective, objective, and functional progress over a reasonable and predictable period
5. Modalities that are physical in nature are not preparatory for other procedures
6. Treatments and modalities that lack evidence of efficacy and/or clinical value separate or apart from (or within) a comprehensive treatment plan for the Member's condition and/or not considered to be a current standard of care. This includes, but is not limited to, infrared light therapy and vasopneumatic device
7. Services that are duplicative and expected to have the same therapeutic outcomes including, but not limited to:
   a. Procedures with multiple modalities or have intersecting physiologic effects (e.g., multiple forms of superficial or deep heating modalities)
   b. Services that are similar and provided as part of an authorized therapy program through another therapy discipline

The following are considered **experimental, investigational, and unproven**:
1. Dry needling
2. Dry hydrotherapy, aquamassage, and hydromassage
3. Elastic therapeutic tape or taping (e.g., Kinesio™ tape, KT TAPE, KT TAPE PRO™, Spidertech™ tape)
4. Hippotherapy (or equestrian therapy)
5. H-WAVE®
6. Intensive Model of Constraint-Induced Movement Therapy
7. Intensive Model of Therapy programs
8. The Interactive Metronome Program
9. Low-level laser therapy
10. MEDEK Therapy
11. Microcurrent Electrical Nerve Stimulation
12. Non-invasive Interactive Neurostimulation (e.g., InterX®)

The following are considered non-covered and **not medically necessary,** as they are educational and non-clinical:
1. Returning to school
2. Driving safety or driver training
3. Vocational rehabilitation programs (or similar programs focused on assisting an individual to return to work)
4. Work hardening programs

Additionally, many benefit plans have exclusion language and/or limitations that impact coverage of OT. Please refer to the individual benefit plan for details.

Specific Rehabilitation Criteria
Providers can access the most current MCG criteria listed below by visiting the Molina Provider Portal.
1. Arthroplasty Rehabilitation
2. Fracture Rehabilitation
3. Neurologic Rehabilitation
4. Osteoarthritis Rehabilitation
5. Pain Rehabilitation
6. Soft Tissue Dysfunction Rehabilitation (Lower Extremity)
7. Soft Tissue Dysfunction Rehabilitation (Spine)
8. Soft Tissue Dysfunction Rehabilitation (Upper Extremity)

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

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SUMMARY OF MEDICAL EVIDENCE

Sheerin et al. (2023) completed a systematic review and meta-analysis to evaluate the effectiveness of occupational therapy interventions for adults with conservatively managed hand, wrist, and forearm conditions. The analysis incorporated 12 studies with a total of 1,429 participants. The main focus was on functional outcomes, while additional measures included occupational performance, satisfaction with performance, pain levels, and overall quality of life. The therapies examined included exercise programs, education, orthoses, assistive devices, and occupation-based approaches targeting conditions such as arthritis, carpal tunnel syndrome, fractures, and tendon injuries. Occupational therapy demonstrated positive effects across several outcomes. Functional improvement was modest, with a standardized mean difference (SMD) of 0.27 (95% confidence interval [CI] 0.00 to 0.53, I^2 = 69%, low-certainty evidence, p = 0.05). In terms of occupational performance, the SMD was 0.83 (95% CI 1.61 to 0.06, I^2 = 91%), reflecting a notable improvement, albeit supported by low-certainty evidence (p = 0.04). Satisfaction with occupational performance also showed gains, with an SMD of 0.74 (95% CI 1.42 to 0.05, I^2 = 89%, low-certainty evidence, p = 0.03). Pain reduction was particularly significant, with a mean difference (MD) of 1.35 (95% CI 0.84 to 1.86, I^2 = 0%, moderate-certainty evidence, p < 0.00001). These findings highlight varying degrees of effectiveness for occupational therapy, with pain relief emerging as a more consistent and reliable benefit compared to the other outcomes, which showed greater variability and lower certainty. The authors concluded that further comprehensive research is recommended to evaluate the effects of occupational therapy interventions on specific upper limb conditions.

Naterstad et al. (2022) completed a systematic review and meta-analysis to assess the efficacy of low-level laser therapy for the treatment of lower extremity tendinopathy and plantar fasciitis. A total of 18 randomized controlled trials with a total of 784 participants were included with 10 trials comparing low-level laser therapy to a placebo, five trials comparing it to other interventions, and three trials assessing it as an add-on intervention. Of the 10 trials comparing low-level laser therapy to a placebo, five trials used exercise therapy or stretching exercises as a cointervention. Other interventions that served as a comparator included extracorporeal shockwave therapy for plantar fasciitis, therapeutic ultrasound, and steroid injections. Eleven of the trials reported using the recommended laser dose for low-level laser therapy, one trial reported using a non-recommended dosage, and six trials were either missing or had indiscernible laser dosage information. An overall significant reduction in pain was noted immediately after low-level laser therapy and continued for 4-12 weeks depending on follow-up period when compared to any control group. An overall significant reduction in disability results was also noted for low-level laser therapy immediately after therapy with the reduction remaining significant 4-9 weeks after therapy when compared to any control group. Subgroup analysis revealed that low-level laser therapy was effective at significantly reducing pain immediately after therapy if the recommended laser dosage was used when compared to all other interventions. This significance was also noted at 4–8-week follow-up points for the placebo control group, 4-12 weeks for other interventions, and 9 weeks for no intervention. Non-recommended laser dosages did not provide a significant reduction in pain while “trials with unknown laser doses significantly favored [low-level laser therapy].” Subgroup analysis for low-level laser therapy compared to each type of intervention favored low-level laser therapy. However, the results were not significant for any subgroup. Limitations of this study included a lack of long-term follow-up data and a lack of blinding of participants and therapists. In addition, there was “some uncertainty about the effect size…due to wide [confidence intervals] and lack of large trials.”

Valera-Calero et al. (2022) completed a systematic review and meta-analysis to assess the efficacy of dry needling and acupuncture in adults with fibromyalgia. A total of 24 studies were included in the systematic review with four studies focusing on dry needling (n = 312 participants) and 20 studies focusing on acupuncture (n = 1497 participants). None of the studies directly compared dry needling and acupuncture. Pain reduction was the most commonly reported outcome in all of the studies and was reported using a variety of pain measurement scales. A total of 15 studies were included for meta-analysis (acupuncture = 11; dry needling = 4). There was an overall significant effect for needle interventions in reducing pain intensity up to 3 months following intervention (p = 0.002), indicating effectiveness of acupuncture and dry needling in the short term. Subgroup analysis found a significant effect for the dry needling group (p = 0.003) but not for the acupuncture group (p = 0.10). However, there was a nonsignificant effect for each follow-up period after 3 months for pain intensity and for all follow-up points for the Fibromyalgia Impact Questionnaire, sleeping/resting quality, depression, and pressure pain threshold. Researchers noted that the evidence level for all outcomes was low to moderate due to serious or very serious inconsistencies noted with individual study results, indicating that “this systematic review should be interpreted carefully.” Researchers recommended additional high-

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quality studies with proper comparators and blinding to assess the efficacy of acupuncture and dry needling as treatment options for fibromyalgia.

Houtrow and Murphy (2019) published an article in consultation with the Council on Children with Disabilities. The authors note the vital role of ensuring that children and youth with disabilities are receiving appropriate community-based services. Without adequate training, general pediatric providers may not be equipped to prescribe appropriate therapy in the appropriate setting for the patient. The report includes the framework of the International Classification of Functioning, Disability and Health (ICF) for understanding the interaction between health conditions and personal and environmental factors that result in disability; children with disabilities and the goals of habilitation and rehabilitation services; the types of therapy services available with their general indications; the locations in which children may receive therapy services and potential facilitators and barriers to securing therapy services; the existing literature regarding the benefits of therapy and how therapy may be dosed to optimize functional outcomes; and recommendations for writing therapy prescriptions.

National and Professional Organizations

The **American Occupational Therapy Association (AOTA)** published the *Standards of Practice for Occupational Therapy* to address the "minimum standards for the practice of occupational therapy." The standards address the education, examination, and licensure requirements for occupational therapy in addition to the standards for 1) professional standing and responsibility, 2) service delivery, 3) screening, evaluation, and reevaluation of clients, 4) intervention processes that includes developing and modifying care plans and working in conjunction with occupational therapy assistants, and 5) outcomes, transition, and discontinuation of occupational therapy interventions and services (Casto et al. 2022).

The AOTA has also published several practice guidelines to establish evidence-based interventions for various conditions and patient populations. The guidelines include, but are not limited to, the following:

- Occupational Therapy Practice Guidelines for Adults Living With Alzheimer's Disease and Related Neurocognitive Disorders (Smallfield et al. 2024)
- Occupational Therapy Practice Guidelines for Adults With Stroke (Hildebrand et al. 2023)
- Occupational Therapy Practice Guidelines for Adults With Traumatic Brain Injury (Wheeler & Acord-Vira 2023)
- Occupational Therapy Practice Guidelines for People With Parkinson's Disease (Wood et al. 2022)
- Occupational Therapy Practice Guidelines for Adults With Chronic Conditions (Fields & Smallfield 2022)
- Occupational Therapy Practice Guidelines for Children and Youth Ages 5-21 Years (Cahill & Beisbier 2020)
- Occupational Therapy Practice Guidelines for Early Childhood: Birth-5 Years (Clark & Kingsley 2020)

SUPPLEMENTAL INFORMATION

Habilitative / Maintenance Therapy: A program designed to maintain or to slow deterioration and must meet criteria to be considered reasonable and necessary. Treatment approaches include, but are not limited to (CMS 2024):

- Evaluation and reevaluation
- Basic ADL training
- Instrumental ADL training
- Muscle reeducation/strengthening/coordination.
- Cognitive training
- Perceptual motor training
- Orthotics (splinting)
- Adaptive equipment fabrication and training
- Environment modification recommendations/training
- Patient/caregiver education/training
- Transfer training
- Functional modality training
- Manual therapy
- Physical agent modality

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Rehabilitative / Restorative Therapy. The purpose of this type of skilled therapy is to reverse, in whole or in part, a previous loss of function (CMS 2024).

Individuals with Disabilities Act (IDEA) and State Resources for Children and Adolescents. The Act is a federally mandated program that provides free and appropriate public education for children with diagnosed learning disabilities throughout the nation and ensures special education and related services to those children.** Funding is governed by IDEA and determines how States and public agencies (such as schools) provide early intervention, special education, and related services to over 7.5 million eligible infants, toddlers, children, and youth with disabilities.

- Children and youth ages 3 through 21 receive special education and related services under IDEA Part B.
- Infants and toddlers (birth through age 2) with disabilities and their families receive early intervention services under IDEA Part C.
- Formula grants are awarded to States to support special education and related services and early intervention services.
- Discretionary grants are awarded to State educational agencies, institutions of higher education, and other non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology development, personnel development, and parent-training and -information centers.

Services provided include, but are not limited to social workers, speech therapists, occupational therapists, school nurses, school psychologists, and/or health or other support staff (e.g., aides). Congress reauthorized the IDEA in 2004 and amended the IDEA through the Every Student Succeeds Act in December 2015.

** Refer to State guidance regarding coverage of speech therapy for the conditions noted above.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
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 (e.g., 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.
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 (e.g., 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.

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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 (e.g., 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.
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.
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, 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	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program, per session (45 minutes or more)
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15

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	minutes
S9129	Occupational therapy, in the home, per diem

CODING DISCLAIMER: Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

04/08/2026	Policy reviewed. No changes to coverage criteria.
04/09/2025	Policy reviewed, No changes to coverage criteria. Updated Summary of Medical Evidence and References.
08/14/2024	Changes to criteria include removal of initial requests being approved for 30 days without prior authorization and maintenance therapy plan for continued therapy. Annual review scheduled for April 2025.
04/10/2024	Policy reviewed, no changes to criteria. IRO Peer Review on February 29, 2024, by a practicing, board-certified physician with specialties in Pain Management and Physical Medicine & Rehabilitation.
04/13/2023	Policy reviewed, criteria wording updated for clarification and included information regarding re-evaluations, discharge, and discontinuation of therapy.
04/13/2022	New policy.

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