MEDICAL COVERAGE POLICY	
SERVICE: Diathermy for Pain	
Policy Number:	**027**
Effective Date:	**06/01/2020**
Last Review:	**04/22/2020**
Next Review Date:	**04/22/2021**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Diathermy for Pain

PRIOR AUTHORIZATION: Not applicable.

POLICY: Diathermy is a part of physical therapy services and should not be billed as separate service. SWHP does **NOT** accept any codes for this nor allows it to be billed as a separate service from a physical therapy visit.

Usage of this device must always be performed by or under the supervision of a qualified physical therapist.

OVERVIEW: Diathermy is a modality used primarily by physical therapists for relief of specific musculoskeletal pain.

Diathermy (e.g., microwave) - Deep, dry heat with high frequency current or microwave to relieve pain and increase movement - supervised. The objective of diathermy is to cause vasodilatation and relieve pain from muscle spasm. Diathermy using deep dry heat with high frequency achieves a greater rise in deep tissue temperature than does microwave. Considered medically necessary as a heat modality for painful musculoskeletal conditions

MANDATES: None

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT codes NOT covered:	97024 Application of a modality to 1 or more areas; diathermy (eg, microwave)
ICD10 codes NOT covered	
HCPCS:	

CMS: NCD as part of an incident physician’s service; see publication 100.3, manual section 150.5

POLICY HISTORY:

Status	Date	Action
New	12/17/2010	New policy
Reviewed	12/18/2011	Reviewed.
Reviewed	8/30/2012	Reviewed.
Reviewed	4/25/2013	No changes
Reviewed	3/27/2014	No changes
Reviewed	4/09/2015	No changes
Reviewed	4/14/2016	Policy language re-written
Reviewed	3/28/2017	No changes
Reviewed	2/20/2018	No changes
Reviewed	4/25/2019	No changes
Reviewed	4/22/2020	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. interventions: Overview and methodology. Phys Ther. 2001;81(10):1629-1640.
2. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for low back pain. Phys Ther. 2001;81(10):1641-1674.
3. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for knee pain. Phys Ther. 2001;81(10):1675-1700.
4. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for neck pain. Phys Ther. 2001;81(10):1701-1717.
5. Philadelphia Panel. Philadelphia Panel evidence-based clinical practice guidelines on selected rehabilitation interventions for shoulder pain. Phys Ther. 2001;81(10):1719-1730.
6. Fischbacher C. Outpatient physiotherapy services for low back pain. STEER: Succint and Timely Evaluated Evidence Reviews. Bazian, Ltd., eds. London, UK: Wessex Institute for Health Research and Development, University of Southampton; 2002;2(3):1-8.
7. Gulick DT. Comparison of tissue heating between manual and hands-free ultrasound techniques. Physiother Theory Pract. 2010;26(2):100-106.
8. http://www.cms.gov/transmittals/downloads/R48NCD.pd