Cigna Medical Coverage Policy- Therapy Services
Range of Motion Testing

Effective Date: 6/15/2026
Next Review Date: 6/15/2027

INSTRUCTIONS FOR USE

Cigna / ASH Medical Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these Cigna / ASH Medical Coverage Policies are based. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Cigna / ASH Medical Coverage Policy. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Determinations in each specific instance may require consideration of:

1) the terms of the applicable benefit plan document in effect on the date of service
2) any applicable laws/regulations
3) any relevant collateral source materials including Cigna-ASH Medical Coverage Policies and
4) the specific facts of the particular situation

Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant guidelines and criteria outlined in this policy, including covered diagnosis and/or procedure code(s) outlined in the Coding Information section of this policy. Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this policy. When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under this policy will be denied as not covered.

Cigna / ASH Medical Coverage Policies relate exclusively to the administration of health benefit plans.

Cigna / ASH Medical Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines.

Some information in these Coverage Policies may not apply to all benefit plans administered by Cigna. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make benefit determinations. References to standard benefit plan language and benefit determinations do not apply to those clients.

GUIDELINES

Medically Necessary

Range of Motion (ROM) Testing is considered medically necessary for medical conditions that impact multiple extremities and trunk musculature when further testing or evaluation beyond what is included in the Evaluation and Management (E/M) service or standard physical therapy, occupational therapy or athletic training evaluation/re-evaluation service is required to develop a plan of care. Examples include but are not limited to:

- spinal cord injury
- traumatic brain injury
- neurologic conditions (e.g. multiple sclerosis, stroke)

- movement Disorders (e.g. Parkinson's disease, cerebral palsy)

Testing must be pertinent to the plan of care and the diagnosis and a written report with interpretation of the results is required.

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side

***Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.**

DESCRIPTION

CPT Codes: 95851–95852 (range of motion [ROM] testing) are designated as separate procedures and require the practitioner's interpretation of the results along with a separate, distinct, dated and signed written report (American Medical Association, 2018). For the typical patient, the Evaluation and Management (E/M) service, physical therapy evaluation and reevaluation (codes 97161-97163, 97164), and occupational therapy evaluation and reevaluation (codes 97165-97167, 97168) include all the necessary objective measurement tools, including range of motion. Baseline measurements may be done with an initial evaluation, and are considered incidental and included in the initial E/M service/evaluation/reevaluation. In addition, assessments, which are separate from evaluations and reevaluations, are included in the therapy treatment services and procedures and should be coded consistent with the intervention for which the assessment is necessary (Centers for Medicare and Medicaid Services [CMS], 2020). The assessments should be provided by therapists or physician/non-physician practitioner (NPP; i.e., physician assistants, nurse practitioners, clinical nurse specialists) and include objective testing and measurement (e.g., ROM) for clinical decision-making regarding the patient's condition and to determine the next step in the treatment plan. On rare occasions, it may be appropriate to perform a thorough range of motion during the course of treatment that is considered separate from the evaluation/reevaluation (CMS, 2020). Patients with complicated conditions may warrant specialized tests and measures with standardized reports. For example, a patient with an incomplete C5 quadriplegia at six months post-injury may need specialized testing for ROM to address specific deficits and goals.

GENERAL BACKGROUND

Testing should be relevant to the plan of care and the diagnosis. Every muscle or joint in the affected extremity or trunk section, as described in the code descriptor, must be tested when coding these procedures. For example:

- Code 95851 is "Range of motion measurements and report; each extremity (excluding hand) or trunk section (spine)". To use this code for extremity ROM testing, every joint of an extremity would need to be tested, with documentation of why such a thorough assessment was warranted. It would not be appropriate to submit code 95851 if only shoulder ROM needed to be tested.

It is not reasonable or necessary for these codes to be performed on a routine basis or to be routinely used for all patients (e.g., monthly or in the place of submitting a standard reevaluation/E/M code. Use of digital devices that provide reports does not justify use of these codes.

DOCUMENTATION GUIDELINES

These codes are typically consultative. It is expected that the administration of these tests will generate material that will be formulated into a report. That report should clearly indicate the purpose and rationale for the test, the test performed with results and how the information affects the treatment plan.

LITERATURE REVIEW

Cools et al. (2014) sought to establish absolute and relative reliability for several procedures measuring the rotational shoulder ROM and strength into internal (IR) and external (ER) rotation strength. Relative reliability was determined by intraclass correlation coefficients (ICC). Absolute reliability was quantified by standard error of measurement (SEM) and minimal detectable change (MDC). Results demonstrated that reliability was good to excellent for IR and ER ROM and isometric strength measurements, regardless of patient or shoulder position or equipment used. Authors concluded that all procedures examined showed acceptable reliability for clinical use. However, patient position and equipment might influence the results. Kolber and Hanney (2012) investigated the intrarater reliability and concurrent validity of active shoulder mobility measurements using a digital inclinometer and goniometer. Authors concluded that the results cautiously support the interchangeable use of goniometry and digital inclinometer for measuring shoulder mobility measurements. Although reliable, clinicians should consider the 95% limits of agreement when using these instruments interchangeably as clinically significant differences are likely to be present. Literature on inclinometer reliability for the lower extremity is lacking. Beshara et al. (2021) systematically reviewed and appraised the literature on the reliability of the Kinect, inertial sensors, smartphone applications and digital inclinometers/goniometers to measure shoulder ROM. Thirty-two studies were included. A total of 24 studies scored "adequate" and 2 scored "very good" for the reliability standards. Only one study scored "very good" and just over half of the studies (18/32) scored "adequate" for the measurement error standards. Good intra-rater reliability (ICC > 0.85) and inter-rater reliability (ICC > 0.80) was demonstrated with the Kinect, smartphone applications and digital inclinometers. Overall, the Kinect and ambulatory sensor-based human motion tracking devices demonstrate moderate-good levels of intra- and inter-rater reliability to measure shoulder ROM. Future reliability studies should focus on improving study design with larger sample sizes and recommended time intervals between repeated measurements. Hahn et al. (2021) aimed to determine whether smartphone applications are reliable and valid to measure range of motion (RoM) in lower extremity joints. Studies that reported reliability or validity of smartphone applications for RoM measurements were included. Twenty-five studies were included in the review. Eighteen studies examined knee RoM, whereof two apps were analysed as having good to excellent reliability and validity for knee flexion ("DrGoniometer", "Angle") and one app showed good results for knee extension ("DrGoniometer"). Eight studies analysed ankle RoM. One of these apps showed good intra-rater reliability and excellent validity for dorsiflexion RoM ("iHandy level"), another app showed excellent reliability and moderate validity for plantarflexion RoM ("Coach's Eye"). All other apps concerning lower extremity RoM had either insufficient results, lacked study quality or were no longer available. Authors concluded that some apps are reliable and valid to measure RoM in the knee and ankle joint. No app can be recommended for hip ROM measurement without restrictions.

Elgueta-Cancino et al. (2022) assessed the validity, reliability, and responsiveness of smartphone applications (apps) to measure neck ROM in people with and without neck pain. Eleven studies, with a total of 376 participants were included. Three types of apps were identified: clinometer apps, compass apps, and other apps of 'adequate' to 'doubtful' risk of bias. A meta-analysis revealed 'good' to 'excellent' intra-rater and inter-rater reliability across the three types of apps. The overall validity was rated from 'moderate' to 'very high' across all apps. The level of evidence was rated as 'low' to 'very low'. Authors concluded that Smartphone applications showed sufficient intra-rater reliability, inter-rater reliability, and validity to measure neck ROM in people with and without neck pain. However, the quality of evidence and the confidence in the findings are low. High-quality research with large sample sizes is needed to further provide evidence to support the measurement properties of smartphone applications for the assessment of neck ROM.

Shepherd et al. (2024) synthesized the current evidence to answer: 1) what digital technologies are currently in use to measure shoulder ROM? 2) Are they reliable? 3) How do they compare to traditional goniometry? Fifteen articles were included, representing 372 participants and 608 shoulders, and reporting data for five device categories; infrared/RGB-D, 3D-motion-analysis, combined 3D/infra-red, 2D-

video-analysis and virtual-reality. Nine studies reported mean bias and 95% limits of agreement (LOA) compared to goniometry. Pooled mean bias was -0.25 degrees (-1.25, 0.75 95% LOA, random effects model) overall. This did not differ by device type (p = 0.83), sensor or non-sensor-based devices (p = 0.62) or plane of movement (p = 0.91). Authors concluded that these devices compare well to goniometry, but are not considered superior to traditional goniometry.

References

1. American Medical Association (AMA) Current Procedural Terminology (CPT) 2023. American Medical Association: Chicago, IL.

2. American Occupational Therapy Association. (n.d.). Retrieved March 30, 2026 from www.aota.org

3. American Physical Therapy Association. (n.d.). Retrieved March 30, 2026 from www.apta.org

4. APTA Guide to Physical Therapist Practice 4.0. American Physical Therapy Association. Published 2023. Accessed March 30, 2026. https://guide.apta.org

5. Beshara P, Anderson DB, Pelletier M, Walsh WR. The Reliability of the Microsoft Kinect and Ambulatory Sensor-Based Motion Tracking Devices to Measure Shoulder Range-of-Motion: A Systematic Review and Meta-Analysis. Sensors (Basel). 2021;21(24):8186. Published 2021 Dec 8.

6. Cools AM, De Wilde L, Van Tongel A, Ceyssens C, Ryckewaert R, Cambier DC. Measuring shoulder external and internal rotation strength and range of motion: comprehensive intra-rater and inter-rater reliability study of several testing protocols. J Shoulder Elbow Surg. 2014 Oct;23(10):1454-61.

7. Elgueta-Cancino E, Rice K, Abichandani D, Falla D. Measurement properties of smartphone applications for the measurement of neck range of motion: a systematic review and meta analyses. BMC Musculoskelet Disord. 2022;23(1):138. Published 2022 Feb 10.

8. Hahn S, Kröger I, Willwacher S, Augat P. Reliability and validity varies among smartphone apps for range of motion measurements of the lower extremity: a systematic review. Biomed Tech (Berl). 2021;66(6):537-555. Published 2021 Nov 15.

9. Kim SG, Lee YS. The intra- and inter-rater reliabilities of lower extremity muscle strength assessment of healthy adults using a hand held dynamometer. J Phys Ther Sci. 2015 Jun;27(6):1799-801.

10. Kolber MJ, Hanney WJ. The reliability and concurrent validity of shoulder mobility measurements using a digital inclinometer and goniometer: a technical report. Int J Sports Phys Ther. 2012 Jun;7(3):306-13.

11. Centers for Medicare and Medicaid Services (CMS), Local Coverage Determination (LCD): Outpatient Physical and Occupational Therapy Services (L33631), National Government Services, Inc., 1/1/2020. Accessed March 30, 2026. Available at URL address: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33631&ver=51&KeyWord=physic&KeyWordLookUp=Title&KeyWordSearchType=Exact&bc=CAAAAAAAAAAA

12. Mentiplay BF, Perraton LG, Bower KJ, Adair B, Pua YH, Williams GP, McGaw R, Clark RA. Assessment of Lower Limb Muscle Strength and Power Using Hand-Held and Fixed Dynamometry: A Reliability and Validity Study. PLoS One. 2015 Oct 28;10(10):e0140822.

13. Schrama PP, Stenneberg MS, Lucas C, van Trijffel E. Intraexaminer reliability of hand- held dynamometry in the upper extremity: a systematic review. Arch Phys Med Rehabil. 2014 Dec;95(12):2444-69.

14. Schunk, C., Reed, K., & Deppeler, D. (Ed.). (2008). Clinical practice guidelines: Examination and intervention for rehabilitation (3rd ed.). Seattle, WA: Therapeutic Associates.

15. Shepherd J, Hansjee S, Divall P, Raval P, Singh HP. How do digital range of motion measurement devices 'measure-up' to traditional goniometry in assessing shoulder range of motion? A systematic review and meta-analysis. Shoulder Elbow. 2024;16(4):363-381. doi:10.1177/17585732231195554

"Cigna Companies" refers to operating subsidiaries of The Cigna Group. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of The Cigna Group. © 2026 The Cigna Group.