Clinical Policy Title: Pet therapy

Clinical Policy Number: CCP.1398

Effective Date: August 1, 2018
Initial Review Date: July 3, 2018
Most Recent Review Date: July 3, 2018
Next Review Date: July 2019

Related policies:

CCP.1399   Equine-assisted therapy for behavioral health
CCP.1400   Art therapy

ABOUT THIS POLICY: AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas’ clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas’ clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas’ clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas’ clinical policies are not guarantees of payment.

Coverage policy

For this policy, pet therapy (animal-assisted therapy) is defined as a goal-oriented, planned, structured, and documented therapeutic intervention directed by health and human service providers as part of their profession (Pet Partners, 2018).

AmeriHealth Caritas considers pet therapy (CPT Code G0176) to be a clinically proven and, therefore, medically necessary component of psychotherapy¹ for members enrolled in the Managed Medical Assistance program when all of the following criteria are met (American Veterinary Medicine Association, 2018; Stewart, 2016):

¹ Psychotherapy is a collaborative treatment based on the relationship between member and therapist, grounded in dialogue, and provided in a supportive, neutral, and nonjudgmental environment (American Psychiatric Association, 2018; American Psychological Association, 2018). Psychotherapy can be provided by various professionals, including psychiatrists, psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, psychiatric nurses, and others with specialized training in psychotherapy.
• There is an agreed upon treatment plan with clearly defined benchmarks and time intervals for evaluating treatment progress.
• Treatment is delivered and/or directed by a health or human service provider working within the scope of their profession.
• Treatment involves a specially trained and evaluated therapy animal.
• Prior authorization of the treatment plan and any subsequent modifications are required.

Limitations:

Renewal of the treatment plan requires prior authorization; the treatment plan will be initiated and managed by the pet therapist.

Pet therapy is not medically necessary if:
• Treatment goals have been achieved and member can maintain benefit independently.
• Treatment goals have not been achieved and member is unlikely to benefit from further treatment.
• Contraindications are present.
• Provided as a stand-alone therapy and not a component of a psychotherapy protocol.

Contraindications to pet therapy include:
• Allergic reactions.
• Increased anxiety around the therapy pet.
• Infections (including zoonosis).
• Risk of harm to the animal or member.

For Medicare members only:

AmeriHealth Caritas considers pet therapy to be investigational and, therefore, not medically necessary.

Alternative covered services:

Standard guideline-directed care.

Background

Animal-assisted interventions (both therapy and activity programs) exploit the bond between humans and animals that, in many ways, is analogous to the bond between parent and child (Cirulli, 2011). Animal-assisted therapy (also called pet therapy) is a goal-oriented intervention in which a specifically trained animal is an integral part of the treatment process (Pet Partners, 2018). It is delivered in a variety of settings and directed by a health or human service provider working within the scope of their profession. The therapeutic goals are to promote improvement in human physical, social, emotional,
and cognitive functioning, and progress is measured and documented (Cirulli, 2011). Dogs and horses are the most common therapy pets, but other domesticated animal have been involved.

Pet therapy differs from other animal-assisted activities, which are generally less-structured, motivational, supportive, recreational, educational, or therapeutic activities usually conducted by volunteers (or trained staff) to enhance quality of life or well-being (Mani, 2016). Examples of other animal-assisted activities include emotional support animals and service animals.

**Searches**

AmeriHealth Caritas searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services.

We conducted searches on June 19, 2018. Search terms were: “Animal Assisted Therapy” (MeSH), “animal facilitated therapy,” and “pet therapy.”

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

We found five systematic reviews (Ein, 2018; Scales, 2018; Lundqvist, 2017; Bert, 2016; Maber-Aleksandrowicz, 2016) and two guidelines (American Veterinary Medicine Association, 2018; Stewart, 2016) for this policy. The evidence for the clinical use of pet therapy consists of low-to-moderate quality studies. Children, patients under psychiatric care, and the elderly were most often studied, and dogs were the most common non-equine animal used. The goals of pet therapy were related to improving quality of life and assisting recovery from or coping with a chronic health problem or behavioral disorder, e.g., reducing debilitating stress and anxiety and improving self-esteem, verbal skills, social skills, and interactions with others.
The research often lacked adequate sample sizes, clearly defined patient populations, and consistent definitions for animal-assisted therapy versus animal-assisted activities or support that are not strictly for therapeutic purposes. All systematic reviews recommend more rigorous study designs and larger samples to validate pet therapy across a range of clinical conditions.

Although optimal therapy protocols and outcome measurements remain ill-defined, the evidence suggests potentially positive effects of pet therapy, such as increased sense of comfort and safety, increased prosocial behaviors, and decreased behavioral problems, across a range of populations with chronic or terminal conditions. However, the mechanisms underpinning any benefits of these interactions are unclear. Adverse effects included allergic reactions, hygiene concerns, increased anxiety, infections (including zoonosis), and animal-related accidents, which could be effectively mitigated with simple infection control protocols, security precautions, and careful patient selection.

Ensuring the welfare of human and animal participants is critical to successful pet therapy programs. The health care provider, animal, and handler (if needed) require specialized training, and a veterinarian may need to be actively involved to ensure the wellness and welfare of the animal and humans involved (American Veterinary Medical Association, 2018). However, unified competencies are lacking. Ultimately, pet therapy should enhance the therapy process and not be used as a stand-alone intervention (Stewart, 2016).

**Policy updates:**

None.

**Summary of clinical evidence:**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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</thead>
<tbody>
<tr>
<td>Ein (2018)</td>
<td>Key points:</td>
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<tr>
<td>The effect of pet therapy on the physiological and subjective stress response</td>
<td>- Meta-analysis of 28 articles with 34 independent samples (1,310 participants).</td>
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<td></td>
<td>- Significant before-after differences in heart rate, self-reported anxiety, and self-reported stress associated with pet therapy exposure, but not in blood pressure.</td>
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<td></td>
<td>- Sample characteristics and modifications to pet therapy significantly moderated treatment effect on stress responses.</td>
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<td></td>
<td>- Evidence suggests pet therapy can be effective for reducing stress reactivity.</td>
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<tr>
<td>Scales (2018)</td>
<td>Key points:</td>
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<tr>
<td>Evidence-based nonpharmacological practices to address behavioral and psychological symptoms of dementia (only results for pet therapy reported)</td>
<td>- Small, preliminary evidence base with some evidence of positive effects on agitation, apathy, and disruptive behavior.</td>
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<td></td>
<td>- In dementia, most studies involved dogs tested daily or one to two times per week for 30 to 90 minutes for one to 12 weeks in a structured or unstructured format.</td>
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<td></td>
<td>- Degree of acceptance varies by participant’s preference for contact with animals.</td>
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<td></td>
<td>- Negative outcomes may include allergic reactions, hygiene concerns, or anxiety/agitation.</td>
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<td></td>
<td>- Socialization/bonding, emotional support, and sensory stimulation may be key elements of</td>
</tr>
<tr>
<td>Citation</td>
<td>Content, Methods, Recommendations</td>
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| Lundqvist (2017) Patient benefit of dog-assisted interventions in health care | **Key points:**  
  - Systematic review of 18 quantitative studies: 14 randomized controlled trials, two pre-post cohort studies, one within subject, time series, and one crossover studies. Treated for psychiatric disorders, stress and mood, and knee arthroplasty pain.  
  - Overall quality: moderate.  
  - There were minor-to-moderate effects of dog-assisted therapy in psychiatric conditions, dog-assisted activities in cognitive disorders, and dog-assisted support in different types of medical interventions, but most outcome measures showed no significant effect. |
| Bert (2016) Animal-assisted intervention: a systematic review of benefits and risks | **Key points:**  
  - Systematic review of 36 studies of patients who were hospitalized; considered the potential risks; heterogeneous in terms of age of patient, health issue, animals used, and the length of interactions, which made comparison problematic.  
  - The most commonly studied populations were children, patients under psychiatric care, and the elderly.  
  - Most studies used dogs, but other animals were effectively used.  
  - Evidence suggests various benefits such as reducing stress, pain, and anxiety. Other outcomes considered were changes in vital signs and nutritional intake.  
  - Major risks were allergies, infections (including zoonosis), and animal-related accidents, effectively mitigated with simple hygiene protocols, security precautions, and careful patient selection.  
  - The literature suggested that the benefits outweighed the risks, by far, but many aspects remain unclear and require research. |
| Maber-Aleksandrowicz (2016) A systematic review of animal-assisted therapy on psychosocial outcomes in people with intellectual disability | **Key points:**  
  - Systematic review of 10 interventional studies. Enrollees were mostly male children and adolescents; the studies measured psychosocial outcomes (behavioral, cognitive, emotional and social).  
  - Overall quality: weak to moderate based on a standardized tool rated as strong, moderate, or weak.  
  - Overall, there was a positive improvement reported from studies for all psychosocial outcomes with some cognitive, behavioral, social, and emotional components reaching statistical significance ($P \leq 0.01$).  
  - More rigorous methodology is required. |

**References**

**Professional society guidelines/other:**


Peer-reviewed references:


Understanding psychotherapy and how it works. 2018. American Psychological Association website. 


Centers for Medicare & Medicaid Services National Coverage Determinations:

No National Coverage Determinations identified as of the writing of this policy.

Local Coverage Determinations:

A52413 Psychiatric Partial Hospitalization Programs – Supplemental Instructions.

L37633 Partial Hospitalization Programs.

L33972 Psychiatric Partial Hospitalization Program.

L34196 Psychiatric Partial Hospitalization Programs.

L33626 Psychiatric Partial Hospitalization Programs.

**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comments</th>
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<tbody>
<tr>
<td>G0176</td>
<td>Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient’s disabling mental health problems, per session (45 minutes or more)</td>
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<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>C00.0-C96.9</td>
<td>Malignant neoplasms</td>
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<tr>
<td>F30.10-F39</td>
<td>Mood affective disorders</td>
<td></td>
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<tr>
<td>F43.10-F43.12</td>
<td>Post-traumatic-stress disorder (PTSD)</td>
<td></td>
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<tr>
<td>F84.0</td>
<td>Autistic disorder</td>
<td></td>
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<tr>
<td>G80.0-G80.9</td>
<td>Cerebral Palsy</td>
<td></td>
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<tr>
<td>T74.31</td>
<td>Adult psychological abuse, confirmed</td>
<td></td>
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<tr>
<td>T74.32</td>
<td>Child psychological abuse, confirmed</td>
<td></td>
</tr>
<tr>
<td>HCPCS Level II Code</td>
<td>Description</td>
<td>Comments</td>
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</tr>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
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