

1 **Clinical Practice Guideline:** **Physical Therapy Medical Policy/Guidelines**

2

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4

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6

7

- Related Policies:
- CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care
  - CPG 30: Laser Therapy (LT)
  - CPG 83: Axial/Spinal Decompression Therapy
  - CPG 110: Medical Record Maintenance and Documentation Practices
  - CPG 111: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations, Re-evaluations, and Consultations
  - CPG 112: Exercise Therapy for Treatment of Non-Specific Low Back Pain
  - CPG 113: Exercise Therapy for Treatment of Neck Pain
  - CPG 119: Spinal Manipulative Therapy for Non-Musculoskeletal Conditions and Related Disorders
  - CPG 121: Passive Physiotherapy (Therapeutic) Modalities
  - CPG 129: Electrodiagnostic Testing
  - CPG 133: Techniques and Procedures Not Widely Supported As Evidence-Based
  - CPG 143: Strapping and Taping
  - CPG 144: Prosthetic Training and Evaluation
  - CPG 146: Range of Motion Testing
  - CPG 148: Wheelchair Management
  - CPG 152: Orthotic Training and Evaluation
  - CPG 155: Occupational Therapy Medical Policy/Guideline
  - CPG 156: Wound Care
  - CPG 157: Lymphedema
  - CPG 165: Autism Spectrum Disorder (ASD) – Outpatient Rehabilitation Services (Speech, Physical, and Occupational Therapy)
  - CPG 166: Speech-Language Pathology/Speech Therapy Guidelines
  - CPG 175: Extra-Spinal Joint Manipulation/Mobilization for the Treatment of Upper Extremity Musculoskeletal Conditions
  - CPG 177: Extra-Spinal Joint Manipulation/Mobilization for the Treatment of Lower Extremity Musculoskeletal Conditions
  - CPG 178: Dry Needling
  - CPG 269: H-Wave® Electrical Stimulation
  - CPG 270: Cognitive Rehabilitation
  - CPG 272: Electric Stimulation for Pain, Swelling and Function in the Clinic Setting
  - CPG 273: Superficial Heat and Cold
  - CPG 274: Deep Heating Modalities (Therapeutic Ultrasound and Diathermy)
  - CPG 275: Mechanical Traction (Provided in a Clinic Setting)
  - CPG 276: MEDEK Therapy
  - CPG 277: Non-invasive Interactive Neurostimulation (InterX®)
  - CPG 286: Intensive Model of Therapy
  - CPG 295: Physical Performance Testing or Measurement
  - CPG 305: Virtual Physical Therapy and Rehabilitation Services

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2

3     **DESCRIPTION**

4     This document addresses Physical Therapy Services which may be delivered by a Physical  
5     Therapist acting within the scope of a professional license. This document also addresses  
6     the processes associated with Medical Necessity Determinations performed by American  
7     Specialty Health (ASH) Clinical Quality Evaluators (CQEs) on services submitted for  
8     review.

9

10    The availability of coverage for rehabilitative and/or habilitative services will vary by  
11    benefit design as well as by State and Federal regulatory requirements. Benefit plans may  
12    include a maximum allowable rehabilitation benefit, either in duration of treatment or in  
13    number of visits or in the conditions covered or type of services covered. When the  
14    maximum allowable benefit is exhausted or if the condition or service are not covered,  
15    coverage will no longer be provided even if the medical necessity criteria described below  
16    are met.

17

18    The determination of medically necessary care, as outlined in this guideline, protects  
19    against inappropriate care that may be wasteful, unsafe, and harmful to the patient, while  
20    assuring approved care is safe, appropriate, curative, and improves the patient’s function  
21    and quality of life. To protect the health and safety of patients, American Specialty Health  
22    (ASH) has implemented medical necessity review strategies to educate practitioners of the  
23    need to implement methods to reduce clinical errors and improve patient safety. These  
24    medical necessity review strategies include encouraging practitioners to adopt evidence-  
25    based health care approaches to patient care, implement professional standards of care, and  
26    follow applicable care management guidelines. Conducting risk management procedures  
27    via medical necessity review minimizes potential adverse outcomes and harm to the patient  
28    and prevents wasteful, unsafe and inappropriate care.

29

30    Care approved through medical necessity review is safe, appropriate, and directed at  
31    specific treatment goal resolution to ensure clinical benefit and improvement to the  
32    patient’s quality of life.

33

- 34       • For risk-reduction and the protection of patients, the review process does not  
35       approve treatment when a condition should be referred to a medical physician, the  
36       treatment is unsafe, or when treatment is not providing measurable health  
37       improvement.
- 38       • For the benefit of patients, the review process approves services when the evidence  
39       and practitioner treatment plan supports the use of conservative treatment for  
40       conditions known to be amenable to the services provided so that patients may  
41       recover from conditions without the need for more costly or high-risk treatments  
      such as prescription opioids, injections, or surgery.

1 **GUIDELINES**

2 **1. PROVIDERS OF PHYSICAL THERAPY SERVICES**

3 Covered, medically necessary rehabilitative or habilitative services must be delivered by a  
 4 qualified Physical Therapist acting within the scope of their license as regulated by the  
 5 Federal and State governments. Some services may be performed by ancillary providers  
 6 (e.g., licensed physical therapist assistant) under the direction and supervision of, and in  
 7 collaboration with, a licensed Physical Therapist; however, generally, only those  
 8 healthcare practitioners who hold an active license, certification, or registration with the  
 9 applicable state board or agency may provide such services. Benefits for services provided  
 10 by these ancillary healthcare providers may also be dependent upon the patient's benefit  
 11 contract language.

12  
 13 Aides and other nonqualified personnel are limited to provision of non-skilled services  
 14 such as preparing the individual, treatment area, equipment, or supplies; assisting a  
 15 qualified therapist or assistant; and transporting individuals.

16  
 17 Physical therapists provide services to patients who have impairments, functional  
 18 limitations, disabilities, or changes in physical function and health status resulting from  
 19 injury, disease, or other causes. Medically necessary physical therapy services must relate  
 20 to a written treatment plan of care and be of a level of complexity that requires the  
 21 judgment, knowledge and skills of a physical therapist to perform and/or supervise the  
 22 services.

23  
 24 A service is not considered a skilled therapy service merely because it is furnished by a  
 25 therapist or by a therapist/therapy assistant under the direct or general supervision, as  
 26 applicable, of a therapist. If a service can be self-administered or safely and effectively  
 27 furnished by an unskilled person, without the direct or general supervision, as applicable,  
 28 of a therapist, the service cannot be regarded as a skilled therapy service even though a  
 29 therapist actually furnishes the service. Similarly, the unavailability of a competent person  
 30 to provide a non-skilled service, notwithstanding the importance of the service to the  
 31 patient, does not make it a skilled service when a therapist furnishes the service.

32  
 33 Services that do not require the professional skills of a therapist to perform or supervise  
 34 are not medically necessary, even if they are performed or supervised by a therapist,  
 35 physician or non-physician practitioner (NPP). Therefore, if a patient's therapy can proceed  
 36 safely and effectively through a home exercise program, self-management program,  
 37 restorative nursing program or caregiver assisted program, physical therapy services are  
 38 not indicated or medically necessary. Physical therapy is used for both rehabilitation and  
 39 habilitation. Skilled physical therapy services may be necessary to improve a patient's  
 40 current condition, to maintain the patient's current condition, or to prevent or slow further  
 41 deterioration of the patient's condition.

1 The plan of care for medically necessary physical therapy services is established by a  
 2 licensed physical therapist. The amount, frequency and duration of the physical therapy  
 3 services must be reasonable (within regional norms and commonly accepted practice  
 4 patterns); the services must be considered appropriate and needed for the treatment of the  
 5 condition and must not be exclusively palliative in nature. Thus, once therapeutic benefit  
 6 has been achieved, or a home exercise program could be used for further gains without the  
 7 need for skilled physical therapy, continuing supervised physical therapy is not considered  
 8 medically necessary.

9  
 10 Rehabilitative services are intended to improve, adapt or restore functions which have been  
 11 impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital  
 12 abnormality involving goals an individual can reach in a reasonable period of time . If no  
 13 improvement is documented after two weeks of treatment, an alternative treatment plan  
 14 should be attempted. Treatment is no longer medically necessary when the individual stops  
 15 progressing toward established goals.

16  
 17 Habilitative services are defined by the National Association of Insurance Commissioners  
 18 as “health care services that help a person keep, learn or improve skills and functioning for  
 19 daily living.” Habilitative services are intended to maintain, develop or improve skills  
 20 needed to perform activities of daily living (ADLs) or instrumental activities of daily living  
 21 (IADLs) which have not (but normally would have) developed or which are at risk of being  
 22 lost as a result of illness, injury, loss of a body part, or congenital abnormality. Examples  
 23 include therapy for a child who is not walking at the expected age.

24  
 25 **Note:** The availability of rehabilitative and/or habilitative benefits for physical therapy  
 26 services, state and federal mandates, and regulatory requirements should be verified and  
 27 followed in addition to the benefit plan provisions and medical necessity criteria defined  
 28 in this document.

29  
 30 The Guide to Physical Therapist Practice, published by the APTA (2014), supports this  
 31 guideline in all areas of physical therapy practice.

## 32 33 **2. REHABILITATIVE PHYSICAL THERAPY SERVICES**

### 34 **Medically Necessary**

35 (1) Rehabilitative physical therapy (PT) services to improve, adapt or restore functions  
 36 which have been impaired or permanently lost and/or to reduce pain as a result of  
 37 illness, injury, loss of a body part, or congenital abnormality are considered **medically**  
 38 **necessary** when **ALL** the following criteria are met:

- 39 1. The services are delivered by a qualified practitioner of physical therapy services  
 40 (i.e., appropriately trained and licensed by the state to perform physical therapy  
 41 services); and

2. Rehabilitative physical therapy occurs when the judgment, knowledge, and skills of a qualified practitioner of physical therapy services (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service due to the complexity and sophistication of the plan of care and the medical condition of the individual, with the goal of improvement of an impairment or functional limitation.
3. The patient’s condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a **reasonable and predictable period of time\*** and will result in a clinically significant level of functional improvement; and
4. Improvement or restoration of function could not be reasonably expected as the individual gradually resumes normal activities without the provision of skilled rehabilitative services; and
5. The documentation objectively verifies progressive functional improvement over specific time frames and clinically justifies the initiation of continuation of rehabilitative services; and
6. The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

**\*Reasonable and predictable period of time:** The specific time frames for which one would expect practical functional improvement is dependent on various factors including whether the services are Rehabilitative or Habilitative services. A reasonable trial of care for rehabilitative services to determine the patient’s potential for improvement in or restoration of function is influenced by the diagnosis; clinical evaluation findings; stage of the condition (acute, sub-acute, chronic); severity of the condition; and patient-specific elements (age, gender, past and current medical history, family history, and any relevant psychosocial factors). Habilitative services may be prolonged and are primarily influenced by the type of ADLs or IADLs which have not developed, or which are at risk of being lost.

(2) A physical therapy evaluation is considered medically necessary for the assessment of a physical impairment.

**Not Medically Necessary**

- 1) Rehabilitative PT services are considered not medically necessary if any of the following is determined:
  1. Rehabilitative services are NOT intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality.
  2. The individual’s condition is strictly of a behavioral nature without any associated motor involvement that impacts functional activities (e.g., ADHD, anxiety).

- 1       3. Improvement or restoration of function could reasonably be expected to improve
- 2       as the individual gradually resumes normal activities without the provision of
- 3       skilled therapy services. For example:
- 4       ○ A patient suffers a transient and easily reversible loss or reduction in function
- 5       which could reasonably be expected to improve spontaneously as the patient
- 6       gradually resumes normal activities.
- 7       ○ A fully functional patient who develops temporary weakness from a brief period
- 8       of bed rest following abdominal surgery.
- 9       4. Therapy services that do not require the skills of a qualified practitioner of PT
- 10      services. Examples include but are not limited to:
- 11      ○ General exercises (basic aerobic, strength, flexibility or aquatic programs) to
- 12      promote overall fitness/conditioning.
- 13      ○ Services for the purpose of enhancing athletic or recreational sports
- 14      performance or for return to sport after injury or surgery.
- 15      ○ Massages and whirlpools for relaxation.
- 16      ○ General public education/instruction sessions.
- 17      ○ Repetitive gait or other activities and services that an individual can practice
- 18      independently and can be self-administered safely and effectively.
- 19      a) Activities that require only routine supervision and NOT the skilled services
- 20      of a physical therapy practitioner.
- 21      b) When a home exercise program is sufficient and can be utilized to continue
- 22      therapy (examples of exceptions include but would not be limited to the
- 23      following: if patient has poor exercise technique that requires cueing and
- 24      feedback, lack of support at home if necessary for exercise program
- 25      completion, and/or cognitive impairment that doesn't allow the patient to
- 26      complete the exercise program).
- 27      5. The expectation does **not** exist that the service(s) will result in a clinically
- 28      significant improvement in the level of functioning within a reasonable and
- 29      predictable period of time (up to 4 weeks).
- 30      ○ If, absent supervised care, function could reasonably be expected to improve at
- 31      the same / similar rate as the individual gradually resumes normal activities,
- 32      then the service is considered **not** medically necessary.
- 33      ○ The patient's condition does not have the potential to improve or is not
- 34      improving in response to therapy; or would not produce a meaningful
- 35      improvement relative to the extent and duration of therapy required; and there
- 36      is an expectation that further improvement is NOT attainable.
- 37      ○ The documentation fails to objectively verify functional progress over a
- 38      reasonable period of time (up to 4 weeks).
- 39      ○ The patient has reached maximum therapeutic benefit.

- 1           6. A passive modality is not preparatory to other skilled treatment procedures or is not  
2           necessary in order to provide other skilled treatment procedures safely and  
3           effectively.
- 4           7. A passive modality has insufficient published evidence to support a clinically  
5           meaningful physiologic effect on the target tissue or improve the potential for a  
6           positive response to care for the condition being treated.
- 7           8. Reevaluations or assessments of a patient’s status that are not necessary to continue  
8           a course of therapy nor related to a new condition or exacerbation for which the  
9           reevaluation will likely result in a change in the treatment plan.
- 10          9. The treatments/services are not supported by and are not performed in accordance  
11          with nationally recognized clinical standards or peer-reviewed literature as  
12          documented in applicable ASH CPGs or other literature accepted by ASH Clinical  
13          Quality committee.
- 14
- 15          (2) The following treatments/programs are considered **not** medically necessary because  
16          they are non-medical, non-rehabilitative, educational, or training in nature. In addition,  
17          these treatments/programs may be specifically excluded under benefit plans:
- 18              • Back school.
- 19              • Vocational rehabilitation programs and any program or evaluation with the primary  
20              goal of returning an individual to work.
- 21              • Work hardening programs.
- 22              • Health and wellness interventions.
- 23              • Education and achievement testing, including Intelligence Quotient (IQ) testing.
- 24              • Educational interventions (e.g., classroom environmental manipulation, academic  
25              skills training and parental training).
- 26              • Services provided within the school setting and duplicated in the rehabilitation  
27              setting.
- 28
- 29          (3) Physical therapy service for executive functioning without any associated motor  
30          involvement that impacts functional activities is considered not medically necessary as  
31          it does not address an underlying medical condition affecting motor deficits.
- 32              • Executive functioning involves learning and cognitive skills which can be  
33              addressed with instruction and practice in a life skills or educational program.
- 34              • Examples of executive functioning includes deficits in the following areas, but not  
35              limited to sustaining and shifting attention, focusing, planning, organizing,  
36              sequencing, managing frustration, modulating emotions that are affecting life skills  
37              and daily activities.
- 38
- 39          (4) Physical therapy for the treatment of any of the following conditions is considered  
40          unproven:



- 1 1. Sexual dysfunction unrelated to musculoskeletal or orthopedic condition.
- 2 2. Scoliosis curvature correction (e.g., Schroth Method).
- 3
- 4 (5) Use of any of the following treatments is considered unproven. Refer to *Techniques*
- 5 *and Procedures Not Widely Supported as Evidence-Based (CPG 133 - S)* and/or the
- 6 specific guideline below for additional information.
- 7 1. Intensive model of constraint-induced movement therapy
- 8 2. Intensive Model of Therapy (IMOT) programs (*Intensive Model of Therapy [CPG*
- 9 *286 – S]*)
- 10 3. Dry hydrotherapy/aquamassage/hydromassage
- 11 4. Non-invasive Interactive Neurostimulation (e.g., InterX®) [*Non-invasive*
- 12 *Interactive Neurostimulation (InterX®) (CPG 277 – S)*]
- 13 5. Microcurrent Electrical Nerve Stimulation (MENS)
- 14 6. H-WAVE® [*H-WAVE® Electrical Stimulation (CPG 269 – S)*]
- 15 7. Spinal manipulation for the treatment of non-musculoskeletal conditions and
- 16 related disorders [*Spinal Manipulative Therapy for Non-Musculoskeletal*
- 17 *Conditions and Related Disorders (CPG 119 – S)*]
- 18 8. Equestrian therapy (e.g., hippotherapy)
- 19 9. MEDEK Therapy [*MEDEK Therapy (CPG 276 – S)*]
- 20 10. The Interactive Metronome Program
- 21 11. Elastic therapeutic tape/taping (e.g., Kinesio™ tape, KT TAPE/KT TAPE PRO™,
- 22 Spidertech™ tape) [*Strapping and Taping (CPG 143 – S)*]
- 23 12. Dry Needling [*Dry Needling (CPG 178 – S)*]
- 24 13. Laser therapy [*Laser Therapy (LT) (CPG 30 – S)*]
- 25 14. Vertebral axial decompression therapy and devices (e.g., VAX-D, DRX,
- 26 DRX2000, DRX3000, DRX5000, DRX9000, DRS, Dynapro™ DX2, Accu-
- 27 SPINA™ System, IDD Therapy® [Intervertebral Differential Dynamics Therapy],
- 28 Tru Tac 401, Lordex Power Traction device, Spinerx LDM) [*Axial/Spinal*
- 29 *Decompression Therapy (CPG 83 – S)*]
- 30

### 31 3. MAINTENANCE PHYSICAL THERAPY SERVICES

32 According to the Centers for Medicare and Medicaid Services (CMS) guidelines, or when  
 33 covered by private carriers, maintenance physical therapy services are a covered benefit  
 34 when skilled physical therapy care is medically necessary to maintain functional status or  
 35 to prevent or slow further deterioration in function. Unlike coverage for rehabilitative  
 36 therapy, coverage for maintenance therapy does not depend on the presence or absence of  
 37 a patient’s potential for improvement for therapy; the deciding factors are always whether  
 38 the services are considered reasonable, effective treatments for the patient’s condition and  
 39 require the skills of a therapist. A maintenance program is considered medically necessary  
 40 when any of the following criteria are met:

- 1 • If the specialized skill, knowledge and judgment of a qualified physical therapist
- 2 are required to establish or design a maintenance program to maintain the patient’s
- 3 current condition or to prevent or slow further deterioration .-
- 4 • If skilled physical therapy services by a qualified physical therapist, or physical
- 5 therapist assistant under the supervision of a qualified therapist, are needed to
- 6 instruct the patient or appropriate caregiver regarding the maintenance program.
- 7 • If skilled physical therapy services are needed for periodic reevaluations or
- 8 reassessments of the maintenance program.

9 Once a maintenance program is designed or established, a maintenance program can  
 10 generally be performed by the patient alone or with the assistance of family member,  
 11 caregiver or unskilled personnel. In such situations, coverage is not medically necessary.  
 12 The performance or delivery of the maintenance therapy program is considered medically  
 13 necessary only when the documentation establishes that the following criteria has been  
 14 met:

- 15
- 16 1. The individualized assessment of a patient’s clinical condition demonstrates that
- 17 the specialized judgment, knowledge, and skills of a physical therapy practitioner
- 18 (skilled care) are necessary for the performance of an effective maintenance
- 19 program.
- 20 2. When the needed therapy procedures required to maintain the patient’s current
- 21 function or to prevent or slow further deterioration are of such complexity and
- 22 sophistication that the skills of a qualified physical therapy practitioner (as defined
- 23 by scope of practice in each state) are required to furnish the therapy procedure; or
- 24 3. The particular patient’s special medical complications require the skills of a
- 25 qualified physical therapy practitioner to furnish a therapy service required to
- 26 maintain the patient’s current function or to prevent or slow further deterioration,
- 27 even if the skills of a physical therapy practitioner are not ordinarily needed to
- 28 perform such therapy procedures.
- 29

30 The plan of care must be developed by the physician, NPP (non-physician practitioner) or  
 31 PT who will provide the PT services.

32

33 **4. HABILITATIVE PHYSICAL THERAPY SERVICES**

34 Habilitative services may or may not be covered services. If the member’s contract  
 35 excludes habilitative services, the contract prevails.

36

37 **Medically Necessary**

38 (1) Habilitative PT services are considered medically necessary when **ALL** the following  
 39 criteria are met:

- 1 1. The therapy is intended to maintain or develop skills needed to perform Activities  
2 of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) which  
3 have not (but normally would have) developed or which are at risk of being lost as  
4 a result of illness (including developmental delay), injury, loss of a body part, or  
5 congenital abnormality.
- 6 2. The physical therapy services are evidence-based and require the judgment,  
7 knowledge, and skills of a qualified practitioner of physical therapy services due to  
8 the complexity and sophistication of the plan of care and the medical condition of  
9 the individual.
- 10 3. There is an expectation that the therapy will assist development of function or  
11 maintain an acceptable level of functioning.
- 12 4. An individual would either not be expected to develop the function or would be  
13 expected to permanently lose the function (not merely experience fluctuation in the  
14 function) without the habilitative service. If the undeveloped or impaired function  
15 is not the result of a loss of body part or injury, a physician experienced in the  
16 evaluation and management of the undeveloped or impaired has confirmed that the  
17 function would not either be expected to develop or would be permanently lost  
18 without the habilitative service. This information also concurs with the written  
19 treatment plan, which is likely to result in meaningful development of function or  
20 prevention of the loss of function.
- 21 5. There is a written treatment plan documenting the short and long-term goals  
22 (including estimated time when goals will be met) of treatment, frequency and  
23 duration of treatment, and what quantitative outcome measures will be used to  
24 assess function objectively.
- 25 6. Documentation objectively verifies that, at a minimum, functional status is  
26 maintained or developed.
- 27 7. The services are delivered by a qualified practitioner of physical therapy services.

28  
29 **Not Medically Necessary**

30 (1) Habilitative PT services are considered not medically necessary if any of the criteria  
31 above are not met or the individual’s condition is strictly of a behavioral nature without  
32 any associated motor involvement that impacts functional activities (e.g., ADHD,  
33 anxiety).

34  
35 **5. REDUNDANT THERAPEUTIC EFFECTS AND REHABILITATIVE OR**  
36 **HABILITATIVE SERVICES**

- 37  
38 1. Redundant rehabilitative or habilitative therapy services expected to achieve the  
39 same therapeutic goal are considered not medically necessary and it would be  
40 inappropriate to provide these services to the same body region during the same  
41 treatment session. This includes treatments, such as but not limited to:

- multiple modalities procedures that have similar or overlapping physiologic effects (e.g., multiple forms of superficial or deep heating modalities).
- massage therapy and myofascial release.
- orthotics training and prosthetic training.
- whirlpool and Hubbard tank.

2. Duplicative (same or similar) rehabilitative or habilitative services provided as part of an authorized therapy program through another therapy discipline are not medically necessary and inappropriate in the provision of care for the same patient.
- When individuals receive physical, occupational, or speech therapy, the therapists should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals. This applies to chiropractic services as well.
  - As an example, when individuals receive manual therapy services from a physical therapist and chiropractic or osteopathic manipulation, the services must be documented as separate and distinct, performed on different body parts, and must be justified and non-duplicative.

## 6. THERAPEUTIC MODALITIES AND PROCEDURES

The CPT® codebook defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy." Modalities may be supervised, which means that the application of the modality doesn't require direct one-on-one patient contact by the practitioner. This means that set-up and application of the modality needs to be supervised by a physical therapist, but they do not need to perform the modality. Modalities may also involve constant attendance, which indicates that the modality requires direct one-on-one patient contact by the practitioner.

Supervised modalities are untimed therapies. Untimed therapies are usually reported only once for each date of service regardless of the number of minutes spent providing this service or the number of body areas to which they were applied. Untimed services billed as more than one unit will require significant documentation to justify treatment greater than one session per day. Examples of supervised modalities include application of:

- Hot or cold packs
- Mechanical traction
- Unattended electrical stimulation (i.e., for pain relief)
- Vasopneumatic devices
- Whirlpool

- 1 • Paraffin bath
- 2 • Diathermy

3  
4 Modalities that require constant attendance, are timed and reported in 15-minute  
5 increments (one unit) regardless of the number of body areas to which they are applied.  
6 Examples of modalities that require constant attendance include:

- 7 • Contrast baths
- 8 • Ultrasound
- 9 • Attended electrical stimulation (i.e., NMES)
- 10 • Iontophoresis

11  
12 The CPT® codebook defines therapeutic procedures as "A manner of effecting change  
13 through the application of clinical skills and/or services that attempt to improve function."  
14 Except for Group Therapy (97150) and Work Hardening/Conditioning (97545-6),  
15 therapeutic procedures require direct (one-on-one) patient contact (constant attendance) by  
16 the Physical Therapist, are timed therapies, and must be reported in units of 15-minute  
17 increments. Only the actual time that the Physical Therapist is directly working with the  
18 patient performing exercises/activities, instruction, or assessments is counted as treatment  
19 time. The time that the patient spends not being treated because of a need for rest or  
20 equipment set up is not considered treatment time. Any exercise/activity that does not  
21 require, or no longer requires, the skilled assessment and intervention of a health care  
22 practitioner is not considered a medically necessary therapeutic procedure. Exercises often  
23 can be taught to the patient or a caregiver as part of a home/self-care program. Examples  
24 of therapeutic procedures that require the Physical Therapist to have direct (one-on-one)  
25 patient contact include:

- 26 • therapeutic exercises
- 27 • neuromuscular reeducation
- 28 • gait training
- 29 • manual therapy (e.g., soft tissue mobilization)
- 30 • therapeutic activities
- 31 • sensory integrative techniques
- 32 • wheelchair training

### 34 **Documentation Requirements to Substantiate Medical Necessity of Therapeutic** 35 **Modalities and Procedures**

36 Proper patient specific evaluation and sufficient documentation is essential to establish the  
37 clinical necessity and effectiveness of each modality and procedure, aid in the  
38 determination of patient outcomes management, and support continuity of patient care. At  
39 a minimum, documentation is required for every treatment day and for each therapy  
40 performed. Each daily record should include: the date of service, the name of each modality

1 and/or procedure performed, the parameters for each modality (e.g., amperage/voltage,  
 2 location of pads/electrodes), area of treatment, total treatment time spent for each therapy  
 3 (mandatory for timed services), the total treatment time for each date of service, and the  
 4 identity of the person(s) providing the services. Failure to properly identify and sufficiently  
 5 document the parameters for each therapy on a daily progress note may result in an adverse  
 6 determination (partial approval or denial).

## 8 **6.1 Passive Care and Active Care**

### 9 **Passive Care**

10 **Passive care** are those interventions applied to a patient with no active participation on the  
 11 part of the patient. Passive care includes various skilled therapeutic procedures (e.g.,  
 12 chiropractic manipulation, manual therapy [CPT® 97140], acupuncture) as well as passive  
 13 therapeutic modalities, such as heat, cold, electrical stimulation, and ultrasound. The  
 14 following guidelines are relevant to the use of passive therapeutic modalities:

- 15 • Generally used to manage the acute inflammatory response, pain, and/or muscle  
 16 tightness or spasm in the early stages of musculoskeletal and related condition  
 17 management (e.g., short term and dependent upon patient condition and  
 18 presentation; a few weeks). When the symptoms that prompted the use of certain  
 19 passive therapeutic modalities begin to subside (e.g., reduction of pain,  
 20 inflammation, and muscle tightness) and function improves, the medical record  
 21 should reflect the discontinuation of those modalities, so as to determine the  
 22 patient’s ability to self-manage any residual symptoms.
- 23 • Use in the treatment of sub-acute or chronic conditions beyond the acute  
 24 inflammatory response time frame requires documentation of the anticipated  
 25 benefit and condition-specific rationale (e.g., exacerbation, inclusion with active  
 26 care as an alternative for pharmacological management of chronic pain) to be  
 27 considered medically necessary. Passive therapeutic modalities can be appropriate  
 28 in these situations when they are preparatory and essential to the safe and effective  
 29 delivery of other skilled therapeutic procedures (e.g., chiropractic manipulation,  
 30 manual therapy [CPT® 97140], therapeutic exercise, acupuncture) that are  
 31 considered medically necessary.
- 32 • Used as a stand-alone treatment is rarely therapeutic, and thus not required or  
 33 indicated as the sole treatment approach to a patient’s condition. Therefore, a  
 34 treatment plan should not consist solely of passive therapeutic modalities but  
 35 should also include skilled therapeutic procedures (e.g., chiropractic manipulation,  
 36 manual therapy [CPT® 97140], therapeutic exercise, acupuncture).
- 37 • Should be based on the most effective and efficient means of achieving the patient’s  
 38 functional goals. Seldom should a patient require more than one (1) or two (2)  
 39 passive therapeutic modalities to the same body part during the therapy session.  
 40 Use of more than two (2) passive therapeutic modalities on a single visit date and

1 for a prolonged period is unusual and should be justified in the documentation for  
 2 consideration of medical necessity.

### 3 **Active Care**

4 **Active care** involves therapeutic interventions that require patients to engage in specific  
 5 exercises, movements, or activities to improve their health. Unlike passive care, which  
 6 relies on external treatments (such as passive therapeutic modalities), active care  
 7 emphasizes patient involvement and responsibility. Examples of active care include,  
 8

- 9 • Therapeutic Exercise Prescription (CPT® Code 97110): This service may be  
 10 considered when healthcare professionals are present and supervising tailored  
 11 exercises performed by the patient based on the patient’s condition, goals, and  
 12 limitations. These exercises may be considered medically necessary to  
 13 restore/develop strength, endurance, range of motion and flexibility which has been  
 14 lost or limited as a result of illness, injury, loss of a body part, or congenital  
 15 abnormality. (Refer to the “Treatment Interventions” section of this CPG for further  
 16 information.)
- 17 • Neuromuscular Reeducation (NMR) (CPT® Code 97112): This service may be  
 18 considered when healthcare professionals are present and supervising tailored  
 19 exercises/movements performed by the patient for the purpose of retraining the  
 20 connection of the brain and muscles, via the nervous system to improve balance,  
 21 coordination, kinesthetic sense, posture and/or proprioception for sitting and/or  
 22 standing activities. This procedure may be considered medically necessary for  
 23 impairments which affect the neuromuscular system. (Refer to the “Treatment  
 24 Interventions” section of this CPG for further information.)
- 25 • Therapeutic Activities Prescription (CPT® code 97530): This service may be  
 26 considered when healthcare professionals are present and supervising tailored  
 27 therapeutic activities or functional activities performed by the patient to improve  
 28 function when there has been a loss of mobility, strength, balance or coordination.  
 29 This intervention may be considered necessary when a patient needs to improve  
 30 function-based activities. (Refer to the “Treatment Interventions” section of this  
 31 CPG for further information.)
- 32 • Independent Exercise Programs: Patients are provided with appropriate exercise  
 33 routines to perform on their own (e.g., home exercise programs [HEPs]).  
 34 Supervised skilled care is provided in the development, modification, and  
 35 progression of the HEPs.
- 36 • Education and Self-Management: Patients receive education about their condition,  
 37 proper body mechanics, and strategies to prevent recurrence. Empowering patients  
 38 with knowledge helps them actively manage their health.

39  
 40 Use of various forms of active care should be started as soon as treatment is initiated and  
 41 documented in the medical record, including instructions supporting independent exercise,

1 education and self-management. Active therapeutic procedures requiring the supervision  
2 of a skilled practitioner (e.g., therapeutic exercise, therapeutic activities, NMR) are  
3 initiated as soon as possible to patient tolerance. Patients should progress from active  
4 therapeutic procedures requiring the supervision of a skilled practitioner to solely an  
5 independent exercise program as soon as reasonably possible.

6  
7 The goal for active therapeutic procedures requiring the supervision of a skilled practitioner  
8 is to provide the necessary skilled care (e.g., exercise technique and movement correction,  
9 technique feedback, exercise program modification, and/or exercise progression) to  
10 empower patients to successfully adopt and maintain an independent exercise program  
11 more efficiently and effectively than if they tried to do it on their own.

12  
13 The length of time per session and the duration for medically necessary, active therapeutic  
14 procedures requiring the supervision of a skilled practitioner will vary depending upon  
15 multiple factors including but not limited to the patient’s knowledge of exercise techniques  
16 and health status of the patient, the diagnosis, co-morbidities, phase of care, chronicity, and  
17 subjective and objective findings, especially the nature and severity of complaints,  
18 orthopedic, neurologic, and functional impairments.

19  
20 The following guidelines are relevant to supervised therapeutic exercise (97110) and other  
21 active therapeutic procedures (e.g., 97112 and 97530) requiring the supervision of a skilled  
22 practitioner:

- 23 • For most patients, the duration of visits for medically necessary care typically does  
24 not exceed four (4) timed units, with the majority of codes utilized as active  
25 therapeutic procedures. The use of active therapeutic procedures is dependent upon  
26 patient tolerance and established goals. More than four (4) timed units per visit  
27 requires documentation to support this level of skilled care in the outpatient setting.
- 28 • More than two (2) or three (3) supervised active therapeutic procedure (e.g., 97110,  
29 97112, 97530) sessions per week is expected to be a rare occurrence. Frequency of  
30 greater than three (3) times per week requires documentation to support this level  
31 of supervision.
- 32 • The duration of the treatment plan for active therapeutic procedures (e.g., 97110,  
33 97112, 97530) varies based on the patient’s condition, progress, treatment goals,  
34 and whether skilled services are necessary. It may span a visit or two, or several  
35 weeks or months, with periodic sessions to achieve functional improvement and  
36 address specific deficits. Certain patient factors may influence this duration (e.g.,  
37 post-surgical status; significant trauma; significant orthopedic/neurological  
38 findings).



## 1 **6.2 Treatment Interventions**

2 Below are descriptions and medical necessity criteria, as applicable, for different treatment  
 3 interventions, including specific modalities and therapeutic procedures associated with  
 4 physical therapy. This material is for informational purposes only and is not indicative of  
 5 coverage, nor is it an exhaustive list of services provided.

### 7 **Hydrotherapy/Whirlpool/Hubbard Tank**

8 These modalities involve supervised use of agitated water in order to relieve muscle spasm,  
 9 improve circulation, or cleanse wounds e.g., ulcers, skin conditions. Hydrotherapy may be  
 10 considered medically necessary for pain relief, muscle relaxation and improvement of  
 11 movement for persons with musculoskeletal conditions or for wound care (cleansing and  
 12 debridement).

### 14 **Fluidotherapy®**

15 This modality is used specifically for acute and subacute conditions of the extremities.  
 16 Fluidotherapy® is a dry superficial thermal modality that transfers heat to soft tissues by  
 17 agitation of heated air and Cellux particles. The indications for this modality are similar to  
 18 paraffin baths and whirlpool and it is an acceptable alternative to other heat modalities for  
 19 reducing pain, edema, and muscle spasm from acute or subacute traumatic or non-traumatic  
 20 musculoskeletal disorders of the extremities, including complex regional pain syndrome  
 21 (CRPS). A benefit of Fluidotherapy® is that patients can perform active range of motion  
 22 (AROM) while undergoing treatment.

### 24 **Vasopneumatic Devices**

25 These special devices apply pressure for swelling/edema reduction, either after an acute  
 26 injury, following a surgical procedure, due to lymphedema, or due to pathology such as  
 27 venous insufficiency. Education sessions for home use are considered medically necessary  
 28 (up to two sessions). Cooling systems such as Game Ready® Systems, Cryocuff, Polar Care  
 29 Wave or any similar cold compression system devices are not considered vasopneumatic  
 30 devices and should not be billed as such.

### 32 **Hot/Cold Packs**

33 Hot packs increase blood flow, relieve pain and increase flexibility. Cold packs decrease  
 34 blood flow to an area for reduction of pain and swelling. They may be considered medically  
 35 necessary for musculoskeletal conditions that include significant pain and or swelling.

### 37 **Paraffin Bath**

38 This modality uses hot wax for application of heat. It is indicated for use to relieve pain  
 39 and increase range of motion of extremities (typically wrists and hands) due to chronic  
 40 joint problems post-injury, or post-surgical scenarios.

1 **Mechanical Traction**

2 This device provides a mechanical pull on the spine (cervical or lumbar) to relieve pain,  
3 spasm, and nerve root compression. Mechanical traction may be considered medically  
4 necessary only when there is no improvement after the application of other evidence-based  
5 therapeutic procedures to significantly improve symptoms for 3 weeks; the patient has  
6 signs of nerve root compression or radiculopathy; it is used in combination with other  
7 evidence-based treatments including therapeutic exercise with extension movements. A  
8 table or chair with moving rollers used against the spine or paraspinal tissues (e.g.,  
9 Spinalator, AKA intersegmental traction) is not a form of mechanical traction.

10  
11 Axial Decompression Therapy (AKA Decompression Therapy or Spinal Decompression  
12 Therapy) is considered unproven and not medically necessary.

13  
14 **Infrared Light Therapy**

15 Infrared light therapy is a form of heat therapy used to increase circulation to relieve muscle  
16 spasm. Other heating modalities are considered superior to infrared lamps and should be  
17 considered unless there is a contraindication to those other forms of heat. Utilization of the  
18 Infrared Light Therapy CPT® code is not appropriate for low level laser treatment. This  
19 also does not refer to Anodyne Therapy System.

20  
21 **Electrical Stimulation**

22 Electrical stimulation is used in different variations to relieve pain, reduce swelling, heal  
23 wounds, and improve muscle function. Functional electric stimulation is considered  
24 medically necessary for muscle re-education (to improve muscle contraction) in the earlier  
25 phases of rehabilitation.

26  
27 **Iontophoresis**

28 Electric current used to transfer certain chemicals (medications) into body tissues. Use of  
29 iontophoresis may be considered medically necessary for the treatment of inflammatory  
30 conditions, such as plantar fasciitis and lateral epicondylitis.

31  
32 **Contrast Baths**

33 This modality is the application of alternative hot and cold baths and is typically used to  
34 treat extremities with subacute swelling or chronic regional pain syndrome (CRPS).  
35 Contrast baths may be considered medically necessary to reduce hypersensitivity reduction  
36 and swelling.

37  
38 **Ultrasound**

39 This modality provides deep heating through high frequency sound wave application. Non-  
40 thermal applications are also possible using the pulsed option. Ultrasound is commonly  
41 used to treat many soft tissue conditions that require deep heating or micromassage to a

1 localized area to relieve pain and improve healing. Ultrasound may be considered  
2 medically necessary to relieve pain and improve healing.

3  
4 **Diathermy (e.g., shortwave)**

5 Shortwave diathermy utilizes high frequency magnetic and electrical current to provide  
6 deep heating to larger joints and soft tissue, and may be considered medically necessary  
7 for pain relief, increased circulation, and muscle spasm reduction. Microwave diathermy  
8 presents an unacceptable risk profile and is considered not medically necessary.

9  
10 **Therapeutic Exercises**

11 Therapeutic exercise includes instruction, feedback, and supervision of a person in an  
12 exercise program specific to their condition. Therapeutic exercise may be considered  
13 medically necessary to restore/develop strength, endurance, range of motion and flexibility  
14 which has been lost or limited as a result of illness, injury, loss of a body part, or congenital  
15 abnormality. Exercise performed by the patient within a clinic facility or other location  
16 (e.g., home, gym) without a physician or therapist present and supervising would be  
17 considered not medically necessary.

18  
19 **Neuromuscular Reeducation (NMR)**

20 NMR generally refers to a treatment technique performed for the purpose of retraining the  
21 connection of the brain and muscles, via the nervous system, the level of communication  
22 required to improve balance, coordination, kinesthetic sense, posture and/or proprioception  
23 for sitting and/or standing activities. The goal of NMR is to develop conscious control of  
24 individual muscles and awareness of position of extremities. The procedure may be  
25 considered medically necessary for impairments which affect the neuromuscular system  
26 (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor  
27 coordination) that may result from musculoskeletal or neuromuscular disease or injury such  
28 as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident  
29 and systemic neurological disease. Example techniques may include proprioceptive  
30 neuromuscular facilitation (PNF), quadriceps activation methods, activities that engage  
31 balance and core control, and desensitization techniques. This does not include  
32 contract/relax or other soft tissue massage techniques. NMR is typically used as the  
33 precursor to Therapeutic Activities implementation.

34  
35 **Aquatic Therapy**

36 Pool therapy (aquatic therapy) is provided individually, in a pool, to debilitated or  
37 neurologically impaired individuals. (The term is not intended to refer to relatively normal  
38 functioning individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.) The goal  
39 is to develop and/or maintain muscle strength and range of motion by reducing forces of  
40 gravity through total or partial body immersion (except for head). Aquatic therapy may be

1 considered medically necessary to develop and/or maintain muscle strength and range of  
 2 motion when it is necessary to reduce the force of gravity through partial body immersion.

### 4 **Gait Training**

5 This procedure involves teaching individuals with neurological or musculoskeletal  
 6 disorders how to ambulate given their disability or to ambulate with an assistive device.  
 7 Assessment of muscle function and joint position during ambulation is considered a  
 8 necessary component of this procedure, including direct visual observation and may  
 9 include video, various measurements, and progressive training in ambulation and stairs.  
 10 Gait training is considered medically necessary for training individuals whose walking  
 11 abilities have been impaired by neurological, integumentary, muscular or skeletal  
 12 abnormalities, surgery, or trauma. This also includes crutch/cane ambulation training and  
 13 re-education.

### 15 **Therapeutic Massage**

16 Therapeutic Massage involves the application of fixed or movable pressure, holding and/or  
 17 causing movement of or to the body, using primarily the hands and may be considered  
 18 medically necessary when performed to restore muscle function, reduce edema, improve  
 19 joint motion, or relieve muscle spasm caused by a specific condition or injury.

### 21 **Soft Tissue Mobilization**

22 Soft tissue mobilization techniques are more specific in nature and include, but are not  
 23 limited to, myofascial release techniques, friction massage, and trigger point techniques.  
 24 Specifically, myofascial release is a soft tissue manual technique that involves  
 25 manipulation of the muscle, fascia, and skin. Skilled manual techniques (active and/or  
 26 passive) are applied to soft tissue to effect changes in the soft tissues, articular structures,  
 27 neural or vascular systems. Examples are facilitation of fluid exchange, restoration of  
 28 movement in acutely edematous muscles, or stretching of shortened connective tissue. This  
 29 procedure is considered medically necessary for treatment of pain and restricted motion of  
 30 soft tissues resulting in functional deficits.

### 32 **Joint Mobilization/Manipulation**

33 Joint mobilization and manipulation are utilized to reduce pain and increase joint mobility.  
 34 Most often mobilizations are indicated for extremity and spine conditions, while  
 35 manipulation may be more generally indicated for spinal conditions.

### 37 **Therapeutic Activities**

38 Therapeutic activities or functional activities (e.g., bending, lifting, carrying, reaching,  
 39 pushing, pulling, stooping, catching and overhead activities may be considered medically  
 40 necessary) to improve function when there has been a loss or restriction of mobility,  
 41 strength, balance or coordination. These dynamic activities must be part of an active

1 treatment plan and directed at a specific outcome. This intervention may be considered  
 2 medically necessary after a patient has completed exercises focused on strengthening and  
 3 range of motion but needs to improve function-based activities.

#### 4 **Activities of Daily Living (ADL) Training**

6 This procedure is considered medically necessary to enable the patient to perform essential  
 7 activities of daily living, instrumental activities of daily living, and self-care including  
 8 bathing, feeding, preparing meals, toileting, dressing, walking, making a bed, and  
 9 transferring from bed to chair, wheelchair or walker. Services provided concurrently by  
 10 physical therapists and occupational therapists may be considered medically necessary if  
 11 there are separate and distinct functional goals.

#### 13 **Self-Care/Home Management Training**

14 Self-Care/Home Management Training involves instructing and training patients with  
 15 impairments in essential activities of daily living (ADL) and self-care activities (e.g.,  
 16 bathing, feeding, dressing, preparing meals, toileting, walking, making bed, and  
 17 transferring from bed to chair, wheelchair or walker). This also includes compensatory  
 18 training for ADLs, safety procedures, and instructions in the use of adaptive equipment and  
 19 assistive technology for use in the home environment. Self-Care/Home Management  
 20 Training may be considered medically necessary only when training is designed to address  
 21 specific needs and goals of the patient for self-management skill development.

#### 23 **Cognitive Skills Development**

24 This procedure is considered medically necessary for persons with acquired cognitive  
 25 deficits resulting from head trauma, or acute neurologic events including cerebrovascular  
 26 accident or pediatric developmental condition, or other situations. It is not appropriate for  
 27 persons without potential for improvement. Occupational/speech therapists with specific  
 28 training typically provide this care, however physical therapists can also provide this care  
 29 through a team approach. This procedure should be aimed at improving or restoring  
 30 specific functions which were impaired by an identified illness or injury.

#### 32 **Orthotic Management and Training**

33 Orthotic management and training may be considered medically necessary when the  
 34 documentation specifically demonstrates that the specific knowledge, skills, and judgment  
 35 of a physical therapist are required to train the patient in the proper use of braces and/or  
 36 splints (orthotics). Many braces or splints do not require specific training by the physical  
 37 therapist in their use and can be safely procured and applied by the patient. Patients with  
 38 cognitive, dexterity, or other significant deficits may need specific training where other  
 39 patients do not.

1 **Prosthetic Training**

2 Prosthetic training may be considered medically necessary when the professional skills of  
3 the practitioner are required to train the patient in the proper fitting and use of a prosthetic  
4 (an artificial body part, such as a limb). Periodic return visits beyond the third month may  
5 be necessary.

6  
7 **Wheelchair Management Training**

8 This procedure is considered medically necessary only when it is part of an active treatment  
9 plan directed at a specific goal. The member must have the capacity to learn from  
10 instructions. Typically, three (3) sessions are adequate.

11  
12 **Active Wound Care Management**

13 The CPT® codebook defines active wound care procedures as those procedures "performed  
14 to remove devitalized tissue and/or necrotic tissue and promote healing" (AMA, current  
15 year). The practitioner is required to have direct one-on-one contact with the patient.  
16 Examples of active wound care management include debridement of an open wound,  
17 including topical application; use of whirlpool or other modalities; and negative pressure  
18 wound therapy.

19  
20 **Electromyography (EMG) and Nerve Conduction Velocity (NCV) Tests**

21 According to the CPT® codebook "Needle electromyographic procedures include the  
22 interpretation of electrical waveforms measured by equipment that produces both visible  
23 and audible components of electrical signals recorded from the muscle(s) studied by the  
24 needle electrode" (AMA, current year). For nerve conduction testing, "motor nerve  
25 conduction study recordings must be made from electrodes placed directly over the motor  
26 point of the specific muscle to be tested. Sensory nerve conduction study recordings must  
27 be made from electrodes placed directly over the specific nerve to be tested." Waveforms  
28 must be reviewed on site in real-time. Reports must be prepared on site by the examiner  
29 and consist of the work product of the interpretation of numerous test results. EMG and  
30 NCV testing is only covered if provided by a qualified health care professional or  
31 physician. Physical therapists who are board certified by the APTA are considered  
32 qualified health professionals. State licensure rules and regulations apply. For more  
33 information, see the *Electrodiagnostic Testing (CPG 129 – S)* clinical practice guideline.

34  
35 **Lymphedema Management**

36 For more information, see the *Lymphedema (CPG 157 – S)* clinical practice guideline.

37  
38 **6.3 Precautions and Contraindications to Therapeutic Modalities and Procedures**

39 **Thermotherapy:**

40 The use of thermotherapy is contraindicated for the following:

- 41
  - Recent or potential hemorrhage

- 1 • Thrombophlebitis
- 2 • Impaired sensation
- 3 • Impaired mentation
- 4 • Local malignant tumor
- 5 • IR irradiation of the eyes
- 6 • Infected areas

7

8 Precautions for use of thermotherapy include:

- 9 • Acute injury or inflammation
- 10 • Pregnancy
- 11 • Impaired circulation
- 12 • Poor thermal regulation
- 13 • Edema
- 14 • Cardiac insufficiency
- 15 • Metal in the area
- 16 • Over an open wound
- 17 • Large scars
- 18 • Over areas where topical counterirritants have recently been applied
- 19 • Demyelinated nerve

20

21 **Cryotherapy:**

22 The use of cryotherapy is contraindicated for the following:

- 23 • Cold hypersensitivity
- 24 • Cold intolerance
- 25 • Cryoglobulinemia
- 26 • Paroxysmal cold hemoglobinuria
- 27 • Raynaud disease or phenomenon
- 28 • Over regenerating peripheral nerves
- 29 • Over an area with circulatory compromise or peripheral vascular disease

30

31 Precautions for cryotherapy include:

- 32 • Over the superficial branch of a nerve
- 33 • Neuropathy
- 34 • Over an open wound
- 35 • Hypertension
- 36 • Poor sensation or mentation

37

38 **Hydrotherapy:**

39 The use of immersion hydrotherapy is contraindicated for the following:

- 1 • Cardiac instability
- 2 • Confusion or impaired cognition
- 3 • Maceration around a wound
- 4 • Bleeding
- 5 • Infection in the area to be immersed
- 6 • Bowel incontinence
- 7 • Severe epilepsy
- 8 • Patients with suicidal ideation
- 9 • Impaired mentation

10

11 Precautions for full body immersion in hot or very warm water include:

12

- Pregnancy
- Multiple Sclerosis
- Poor thermal regulation

13

14

15

### 16 **Mechanical Traction:**

17

Contraindications for mechanical traction include:

18

- Where motion is contraindicated
- Acute injury or inflammation
- Joint hypermobility or instability
- Peripheralization of symptoms with traction
- Uncontrolled hypertension
- Congenital spinal deformity
- Fractures
- Impaired mentation

19

20

21

22

23

24

25

26

27 Precautions for mechanical traction include:

28

- Structural diseases or conditions affecting the tissues in the area to be treated (e.g., tumor, infection, osteoporosis, RA, prolonged systemic steroid use, local radiation therapy)
- When pressure of the belts may be hazardous (e.g., with pregnancy, hiatal hernia, vascular compromise, osteoporosis)
- Cardiovascular disease
- Displaced annular fragment
- Medial disc protrusion
- Cord compression
- When severe pain fully resolves with traction
- Claustrophobia or other psychological aversion to traction
- Inability to tolerate prone or supine position

29

30

31

32

33

34

35

36

37

38

39



- 1       • Disorientation  
2

3 Additional precautions for *cervical* traction:

- 4       • TMJ problems  
5       • Dentures  
6

7 **Shortwave Diathermy:**

8 The use of thermal shortwave diathermy (SWD) is contraindicated for the following

- 9       • Any metal in the treatment area or on/in the body.  
10       • Malignancy  
11       • Eyes  
12       • Testes  
13       • Growing epiphyses  
14       • Recent or potential hemorrhage  
15       • Thrombophlebitis  
16

17 Contraindications for all forms of SWD:

- 18       • Implanted or transcutaneous neural stimulators including cardiac pacemakers  
19       • Pregnancy  
20       • Impaired sensation  
21       • Impaired mentation  
22       • Infected areas  
23

24 Precautions for all forms of SWD:

- 25       • Near electronic or magnetic equipment  
26       • Obesity  
27       • Copper-bearing intrauterine contraceptive devices  
28

29 **Electrical Currents:**

30 Contraindications for use of electrical currents:

- 31       • Demand pacemakers, implantable defibrillator, or unstable arrhythmia  
32       • Placement of electrodes over carotid sinus and heart  
33       • Areas where venous or arterial thrombosis or thrombophlebitis is present  
34       • Pregnancy – over or around the abdomen or low back  
35       • Infected areas  
36

37 Precautions for electrical current use:

- 38       • Cardiac disease  
39       • Impaired mentation

- 1       • Impaired sensation
- 2       • Malignant tumors
- 3       • Areas of skin irritation or open wounds

#### 5       **Ultrasound:**

6       Contraindications to the use of ultrasound include:

- 7       • Malignant tumor
- 8       • Pregnant uterus
- 9       • Central nervous tissue
- 10      • Joint cement
- 11      • Plastic components
- 12      • Pacemaker or implantable cardiac rhythm device
- 13      • Thrombophlebitis
- 14      • Eyes
- 15      • Reproductive organs
- 16      • Impaired sensation
- 17      • Impaired mentation
- 18      • Infected areas

19  
20      Precautions for ultrasound include:

- 21      • Acute inflammation
- 22      • Epiphyseal plates
- 23      • Fractures
- 24      • Breast implants

25  
26      Pediatric Patients:

27      The use of electrical muscle stimulation, SWD, thermotherapy, cryotherapy, ultrasound,  
28      laser/light therapy, immersion hydrotherapy, and mechanical traction is contraindicated if  
29      the patient cannot provide the proper feedback necessary for safe application.

#### 30 31      **Unproven:**

32      In addition to the contraindications listed above, there are a wide range of services which  
33      are considered unproven, pose a significant health and safety risk, are scientifically  
34      implausible and/or are not widely supported as evidence based. Such services would be  
35      considered not medically necessary and include, but are not limited to:

- 36      • Axial/Spinal decompression
- 37      • Dry needling
- 38      • Laser therapy
- 39      • Manual muscle testing to diagnosis non-neuromusculoskeletal conditions

- 1 • Microcurrent Electrical Nerve Stimulation (MENS)
- 2 • Other unproven procedures (see the *Techniques and Procedures Not Widely*
- 3 *Supported as Evidence-Based (CPG 133 – S)* clinical practice guideline for
- 4 complete list)

## 6 7. CLINICAL DOCUMENTATION

7 Medical record keeping is an essential component of patient evaluation and management.  
 8 Medical records should be legible and should contain, at a minimum sufficient information  
 9 to identify the patient, support the diagnosis, justify the treatment, accurately document the  
 10 results, indicate advice and cautionary warnings provided to the patient and provide  
 11 sufficient information for another practitioner to assume continuity of the patient’s care at  
 12 any point in the course of treatment. Good medical record keeping improves the likelihood  
 13 of a positive outcome and reduces the risk of treatment errors. It also provides a resource  
 14 to review cases for opportunities to improve care, provides evidence for legal records, and  
 15 offers necessary information for third parties who need to review and understand the  
 16 rationale and type of services rendered (e.g., medical billers and auditors/reviewers.)

17  
 18 Outcome measures are important in determining effectiveness of a patient’s care. The use  
 19 of standardized tests and measures early in an episode of care establishes the baseline status  
 20 of the patient, providing a means to quantify change in the patient's functioning. Outcome  
 21 measures provide information about whether predicted outcomes are being realized. When  
 22 comparison of follow-up with baseline outcome metrics does not demonstrate minimal  
 23 clinically important difference (MCID) (minimal amount of change in a score of a valid  
 24 outcome assessment tool), the treatment plan should be changed or be discontinued. Failure  
 25 to use Functional Outcome Measures (FOMs) / Outcome Assessment Tools (OATs) may  
 26 result in insufficient documentation of patient progress and may result in an adverse  
 27 determination (partial approval or denial) of continued care.

### 29 7.1 Evaluation and Re-evaluations

30 The initial evaluation is usually completed in a single session. The initial evaluation should  
 31 document the necessity of a course of therapy through objective findings and subjective  
 32 patient/caregiver self-reporting. Initial evaluations are completed to determine the medical  
 33 necessity of initiating rehabilitative therapy or skilled instruction in maintenance activities  
 34 that the patient and/or caregiver can perform at home. The physical therapist performs an  
 35 initial examination and evaluation to establish a physical therapy diagnosis, prognosis, and  
 36 plan of care prior to intervention. Determination of referral to another health care  
 37 practitioner is also an essential part of an initial evaluation. An initial evaluation for a new  
 38 condition by a Physical Therapist is defined as the evaluation of a patient:

- 39 • For whom this is the first encounter with the practitioner or practitioner group;

- 1 • Who presents with:
  - 2 ○ A new injury or new condition; or
  - 3 ○ The same or similar complaint after discharge from previous care.
- 4 • Choice of code is dependent upon the level of complexity.

5  
6 The evaluation codes reflect three (3) levels of patient presentation: low-complexity,  
7 moderate-complexity, and high-complexity. Four components are used to select the  
8 appropriate PT evaluation CPT® code. These include:

- 9 1. Patient history and comorbidities;
- 10 2. Examination and the use of standardized tests and measures;
- 11 3. Clinical presentation;
- 12 4. Clinical decision making.

13  
14 Relevant CPT® Codes: 97161, 97162, and 97163 – Physical Therapy evaluation

15  
16 The physical therapist evaluation:

- 17 • Is documented, dated, and appropriately authenticated by the physical therapist who
- 18 performed it.
- 19 • Identifies the physical therapy needs of the patient.
- 20 • Incorporates appropriate tests and measures to facilitate outcome measurement.
- 21 • Produces data that are sufficient to allow evaluation, diagnosis, prognosis, and the
- 22 establishment of a plan of care.

23  
24 The physical therapist's plan of care should be sufficient to determine the medical necessity  
25 of treatment, including:

- 26 • The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis.
- 27 • A reasonable estimate of when the goals will be reached.
- 28 • Long-term and short-term goals that are specific, quantitative and objective.
- 29 • Physical therapy evaluation pertinent findings.
- 30 • The frequency and duration of treatment.
- 31 • Rehabilitation or habilitation prognosis.
- 32 • The specific treatment techniques and/or exercises to be used in treatment.
- 33 • Signature of the patient's physical therapist.

34  
35 Re-evaluations are distinct from therapy assessments. There are several routine  
36 reassessments that are not considered re-evaluations. These include ongoing reassessments  
37 that are part of each skilled treatment session, progress reports, and discharge summaries.  
38 Re-evaluation provides additional objective information not included in documentation of  
39 ongoing assessments, treatment or progress notes. Assessments are considered a routine  
40 aspect of intervention and are not billed separately from the intervention. Continuous

1 assessment of the patient’s progress is a component of the ongoing therapy services and is  
 2 not payable as a re-evaluation.

3  
 4 Re-evaluation services are considered medically necessary when all of the following  
 5 conditions are met:

- 6 • Re-evaluation is not a recurring routine assessment of patient status
- 7 • The documentation of the re-evaluation includes all of the following elements:
  - 8 ○ An evaluation of progress toward current goals
  - 9 ○ Making a professional judgment about continued care
  - 10 ○ Making a professional judgment about revising goals and/or treatment or
  - 11 terminating services

12  
 13 **AND the following indication is documented:**

- 14 • An exacerbation or significant change in patient/client status or condition

15  
 16 Relevant CPT® Codes: 97164 – Physical Therapy re-evaluation

17  
 18 In order to reflect that continued PT services are medically necessary, intermittent progress  
 19 reports must demonstrate that the individual is making functional progress.

20  
 21 **7.2 Treatment Sessions**

22 A physical therapy intervention is the purposeful interaction of the physical therapist and/or  
 23 physical therapist assistant with the patient and, when appropriate, with other individuals  
 24 involved in patient care, using various physical therapy procedures and techniques to  
 25 produce changes in the condition that are consistent with the diagnosis and prognosis.  
 26 Physical therapy interventions consist of coordination, communication, and  
 27 documentation; patient-related and family/caregiver instruction; and procedural  
 28 interventions. Physical therapists aim to alleviate impairment and functional limitation by  
 29 designing, implementing, and modifying therapeutic interventions. A physical therapy  
 30 session can vary in duration; however, treatment sessions lasting more than one hour per  
 31 day are infrequent in outpatient settings (payor medical or reimbursement coverage policy  
 32 may limit unit or session duration per date of service). Treatment sessions for more than  
 33 one hour per day may be medically appropriate but must be supported in the documented  
 34 plan of care and based on a patient's medical condition. A physical therapy session may  
 35 include:

- 36 • Evaluation or reevaluation
- 37 • Therapeutic exercise, including neuromuscular reeducation, strengthening,  
 38 coordination, and balance
- 39 • Functional training in self-care and home management including activities of daily  
 40 living (ADL) and instrumental activities of daily living (IADL)

- 1 • Functional training in and modification of environments (e.g., home, work, school,
- 2 or community), including body mechanics and ergonomics
- 3 • Manual therapy techniques, including soft tissue mobilization, joint mobilization,
- 4 and manual lymphatic drainage
- 5 • Assessment, design, fabrication, application, fitting, and training in assistive
- 6 technology, adaptive devices, and orthotic devices
- 7 • Training in the use of prosthetic devices
- 8 • Integumentary and wound care and protection techniques
- 9 • Electrotherapeutic modalities
- 10 • Physical agents and mechanical modalities
- 11 • Community functional reintegration
- 12 • Training of the patient, caregivers, and family/parents in home exercise and activity
- 13 programs
- 14 • Skilled reassessment of the individual's problems, plan, and goals as part of the
- 15 treatment session

16

17 Documentation of treatment should include:

18

- 18 • Date of treatment
- 19 • Subjective complaints and current status (including functional deficits and ADL
- 20 restrictions)
- 21 • Description/name of each specific treatment intervention provided that match the
- 22 CPT® codes billed, including:
  - 23 ○ Treatment time for each modality or procedure performed
  - 24 ○ Parameters of any modality or procedure, (e.g., voltage/amperage,
  - 25 pad/electrode placement, area of treatment, types of exercises/activities, and
  - 26 intended goal of each therapy)
- 27 • The patient's response to each service and to the entire treatment session
- 28 • Any progress toward the goals in objective, measurable terms using consistent and
- 29 comparable methods
- 30 • Any changes to the plan of care
- 31 • Recommendations for follow-up visit(s)
- 32 • Signature/electronic identifier, name and credentials of the treating clinician

33

### 34 **7.3 Discharge/Discontinuation of Intervention**

35

36 The physical therapist discharges the patient from physical therapy services when the

37 anticipated goals or expected outcomes for the patient have been achieved. The physical

38 therapist discontinues intervention when the patient is unable to continue to progress

39 toward goals or when the physical therapist determines that the patient will no longer

benefit from physical therapy.

1 The physical therapy discharge documentation includes:

- 2 • The status of the patient at discharge and the goals and outcomes attained
- 3 • Appropriate date and authentication by the physical therapist who performed the
- 4 discharge
- 5 • When a patient is discharged prior to attainment of goals and outcomes, the status
- 6 of the patient and the rationale for discontinuation
- 7 • Final functional status
- 8 • Proposed self-care recommendations, if applicable
- 9 • Referrals to other health care practitioners/referring physicians, as appropriate
- 10 • If the patient self- discharges, documentation of final status and if known, the
- 11 reason for discontinuation of services

12  
13 **7.4 Duplicated / Insufficient Information**

14 (1) Entries in the medical record should be contemporaneous, individualized, appropriately  
15 comprehensive, and made in a chronological, systematic, and organized manner.  
16 Duplicated/nearly duplicated medical records (AKA cloned records) are not acceptable. It  
17 is not clinically reasonable or physiologically feasible that a patient’s condition will be  
18 identical on multiple encounters. (Should the finding be identical for encounters, it would  
19 be expected that treatment would end because patient is not making progress toward current  
20 goals.)

21  
22 This includes, but is not limited to:

- 23 • duplication of information from one treatment session to another (for the same or
- 24 different patient[s]);
- 25 • duplication of information from one evaluation to another (for the same or different
- 26 patient[s]).

27  
28 Duplicated medical records do not meet professional standards of medical record keeping  
29 and may result in an adverse determination (partial approval or denial) of those services.  
30

31 (2) The use of a system of record keeping that does not provide sufficient information (e.g.,  
32 checking boxes, circling items from lists, arrows, travel cards with only dates of visit and  
33 listings). These types of medical record keeping may result in an adverse determination  
34 (partial approval or denial) of those services.

35  
36 Effective and appropriate record keeping that meets professional standards of medical  
37 record keeping document with adequate detail a proper assessment of the patient’s status,  
38 the nature and severity of his/her complaint(s) or condition(s), and/or other relevant clinical  
39 information (e.g., history, parameters of each therapy performed, objective findings,  
40 progress towards treatment goals, response to care, prognosis).

1 **7.5 Centers for Medicare and Medicaid Services (CMS)**

2 For Medicare and Medicaid services, medical records keeping must follow and be in  
3 accordance with Medicare and any additional state Medicaid required documentation  
4 guidelines.

5  
6 **8. CLINICAL REVIEW PROCESS**

7 Medical necessity evaluations require approaching the clinical data and scientific evidence  
8 from a global perspective and synthesizing the various elements into a congruent picture  
9 of the patient's condition and need for skilled treatment intervention. Clinical review  
10 decisions made by the CQEs are based upon the information provided by the treating  
11 practitioner in the submitted documentation and other related findings and information.  
12 Failure to appropriately document pertinent clinical information may result in adverse  
13 determinations (partial approval or denial) of those services. Therefore, thorough  
14 documentation of all clinical information that established the diagnosis/diagnoses and  
15 supports the intended treatment is essential.

16  
17 **8.1 Definition of Key Terminology used in Clinical Reviews**

18 **Elective/Convenience Services**

19 Examples of elective/convenience services include: (a) preventive services; (b) wellness  
20 services; (c) services not necessary to return the patient to pre-illness/pre-injury functional  
21 status and level of activity; (d) services provided after the patient has reached MTB.  
22 (Elective/convenience services may not be covered through specific client or ASH  
23 benefits.)

24  
25 **Minimal Clinically Important Difference (MCID)**

26 The MCID is the minimal amount of change in a score of a valid outcome assessment tool  
27 that indicates an actual improvement in the patient's function or pain. Actual significance  
28 of outcome assessment tool findings requires correlation with the overall clinical  
29 presentation, including updated subjective and objective examination/evaluation findings.

30  
31 **Maximum Therapeutic Benefit (MTB)**

32 MTB is the patient's health status when the application of skilled therapeutic services has  
33 achieved its full potential (which may or may not be the complete resolution of the patient's  
34 condition.) At the point of MTB, continuation of the same or similar skilled treatment  
35 approach will not significantly improve the patient's impairments and function during this  
36 episode of care.

37  
38 If the patient continues to have significant complaints, impairments, and documented  
39 functional limitations, one should consider the following:

- 40
  - Altering the treatment regimen such as utilizing a different physiological approach
- 41
  - to the treatment of the condition, or decreasing the use of passive care (modalities,



- 1           massage etc.) and increasing the active care (therapeutic exercise) aspects of  
 2           treatment to attain greater functional gains;
- 3           • Reviewing self-management program including home exercise programs; and/or
  - 4           • Referring the patient for consultation by another health care practitioner for
  - 5           possible co-management or a different therapeutic approach.

6

### 7           **Preventive Services**

8           Preventive services are designed to reduce the incidence or prevalence of illness,  
 9           impairment, and risk factors, and to promote optimal health, wellness, and function. These  
 10          services are not designed or performed to treat or manage a specific health condition.  
 11          (Preventive services may or may not be covered under specific clients or through ASH  
 12          benefits.)

13

### 14          **Acute**

15          The stage of an injury, illness, or disease, in which the presence of clinical signs and  
 16          symptoms is less than six weeks in duration, typically characterized by the presence of one  
 17          or more signs of inflammation or other adaptive response.

18

### 19          **Sub-Acute**

20          The stage of an injury, illness, or disease, in which the presence of clinical signs and  
 21          symptoms is greater than six weeks, but not greater than twelve weeks in duration.

22

### 23          **Chronic**

24          The stage of an injury, illness, or disease, in which the presence of clinical signs and  
 25          symptoms is greater than twelve weeks in duration.

26

### 27          **Red Flag(s)**

28          Signs and symptoms presented through history or examination/assessment that warrant  
 29          more detailed and immediate medical assessment and/or intervention.

30

### 31          **Yellow Flag(s)**

32          Adverse prognostic indicators with a psychosocial predominance associated with chronic  
 33          pain and disability. Yellow flags signal the potential need for more intensive and complex  
 34          treatment and/or earlier specialist referral.

35

### 36          **Co-Morbid Condition(s)**

37          The presence of a concomitant condition, that may inhibit, lengthen, or alter in some way  
 38          the expected response or approach to care.

1 **Health Equity (HE)**

2 The attainment of the highest level of health for all people, where everyone has a fair and  
3 just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual  
4 orientation, gender identity, socioeconomic status, geography, preferred language, or other  
5 factors that affect access to care and health outcomes (Centers for Medicare & Medicaid  
6 Services, 2024).

7  
8 **Social Determinants of Health (SDoH)**

9 The conditions in the environments where people are born, live, learn, work, play, worship,  
10 and age that affect a wide range of health, functioning, and quality-of-life outcomes and  
11 risks. Five domains: 1) Economic stability; 2) Education access and quality; 3) Health care  
12 access and quality; 4) Neighborhood and built environment; 5) Social and community  
13 context (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

14  
15 **8.2 Clinical Review for Medical Necessity**

16 The goal of the CQEs during the review and decision-making process is to approve, as  
17 appropriate, those clinical services necessary to return the patient to pre-clinical/pre-  
18 morbid health status, stabilize, or functionally improve a chronic condition, as supported  
19 by the documentation presented. The CQE is to evaluate if the documentation and other  
20 clinical information presented by the practitioner has appropriately substantiated the  
21 patient's condition and appropriately justifies the treatment plan that is presented.

22  
23 **Approval**

24 ASH CQEs have the responsibility to approve appropriate care for all services that are  
25 medically necessary. The CQEs assess the clinical data supplied by the practitioner in order  
26 to determine whether submitted services and/or the initiation or continuation of care has  
27 been documented as medically necessary. The practitioner is accountable to document the  
28 medical necessity of all services submitted/provided. It is the responsibility of the peer  
29 CQE to evaluate the documentation in accordance with their training, understanding of  
30 practice parameters, and review criteria adopted by ASH through its clinical committees.

31  
32 The following items influence clinical service approvals:

- 33 • No evidence of contraindication(s) to services submitted for review;
- 34 • Complaints, exam findings, and diagnoses correlate with each other;
- 35 • Treatment plan is supported by the nature and severity of complaints;
- 36 • Treatment plan is supported by exam findings;
- 37 • Treatment plan is expected to improve symptoms (e.g., pain, function) within a  
38 reasonable period of time;
- 39 • Maximum therapeutic benefit has not been reached;
- 40 • Treatment plan requires the skills of the practitioner; and

- Demonstration of progression toward active home/self-care and discharge.

### **Partial Approval**

Occurs when only a portion of the submitted services are determined to be medically necessary services. The partial approval may refer to a decrease in treatment frequency, treatment duration, number of Durable Medical Equipment (DME)/supplies/appliances, number of therapies, or other services from the original amount/length submitted for review. This decision may be due to any number of reasons, such as:

- the practitioner’s documentation of the history and exam findings are inconsistent with the clinical conclusion(s)
- the treatment dosage (frequency/duration) submitted for review is not supported by the underlying diagnostic or clinical features
- the need to initiate only a limited episode of care in order to monitor the patient’s response to care

Additional services may be submitted and reviewed for evaluation of the patient’s response to the initial trial of care. If the practitioner or patient disagrees with the partial approval of services, they contact the CQE listed on their response form to discuss the case, submit additional documentation through the Reopen process, or submit additional documentation to appeal the decision through the Provider Appeals and Member Grievances process.

### **Non-approval / Denial**

Occurs when none of the services submitted for review are determined to be medically necessary services. The most common causes for a non-approval/denial of all services are administrative or contractual in nature (e.g., ineligibility, reached plan benefit limits, non-coverage). Clinically, it is appropriate to deny continued/ongoing care if the patient’s condition(s) are not, or are no longer, responding favorably to the services being rendered by the treating practitioner, or the patient has reached maximum therapeutic benefit.

### **Additional / Continued Care**

Approval of additional treatment/services requires submission of additional information, including the patient’s response to care and updated clinical findings. In cases where an additional course of care is submitted, the decision to approve additional services will be based upon the following criteria:

- The patient has made clinically significant progress under the initial treatment plan/program based on a reliable and valid outcome tool or updated subjective, functional, and objective examination findings.
- Additional clinically significant progress can be reasonably expected by continued treatment. (The patient has not reached MTB or maximum medical improvement.)

- There is no indication that immediate care/evaluation is required by other health care professionals.

Any exacerbation or flare-up of the condition that contributes to the need for additional treatment/services must be clearly documented.

The clinical information that the CQE expects to see when evaluating the documentation in support of the medical necessity of submitted treatment/services should be commensurate with the nature and severity of the presenting complaint(s) and scope of the practitioner of services and may include but is not limited to:

- History
- Physical examination/evaluation
- Documented treatment plan and goals
- Estimated time of discharge

In general, the initiation of care is warranted if there are no contraindications to prescribed care, there is reasonable evidence to suggest the efficacy of the prescribed intervention, and the intervention is within the scope of services permitted by State or Federal law. The treatment submission for a disorder is typically structured in time-limited increments depending on clinical presentation. Dosage (frequency and duration of service) should be appropriately correlated with clinical findings, potential complications/barriers to recovery and clinical evidence. When the practitioner discovers that a patient is nonresponsive to the applied interventions within a reasonable time frame, re-assessment and treatment modification should be implemented and documented. If the patient’s condition(s) worsen, the practitioner should take immediate and appropriate action to discontinue or modify care and/or make an appropriate healthcare referral.

Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary. If a patient’s recovery can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.

**8.3 Critical Factors during Clinical Reviews**

The complexity and/or severity of historical factors, symptoms, examination findings, and functional deficits play an essential role to help quantify the patient’s clinical status and assess the effectiveness of planned interventions over time. CQEs consider patient-specific variables as part of the medical necessity verification process. The entire clinical picture must be taken into consideration with each case evaluated based upon unique patient and condition characteristics.

1 Such variables may include, but not be limited to co-morbid conditions and other barriers  
 2 to recovery, the stage(s) of the condition(s), mechanism of injury, severity of the  
 3 symptoms, functional deficits, and exam findings, as well as social and psychological status  
 4 of the patient and the available support systems for self-care. In addition, the patient’s age,  
 5 symptom severity, and the extent of positive clinical findings may influence duration,  
 6 intensity, and frequency of services approved as medically necessary. For example:

- 7 • Severe symptomatology, exam findings, and/or functional deficits may require  
 8 more care overall (e.g., longer duration, more services per encounter, and frequency  
 9 of encounters that the average); these patients require a higher frequency; but may  
 10 require short-term trials of care initially to assess patient response to care.
- 11 • Less severe symptomatology, exam findings and/or functional deficits usually  
 12 require less care (e.g., shorter duration, fewer services per encounter, and frequency  
 13 of encounters that the average); overall but may allow for less oversight and a  
 14 longer initial trial of care.
- 15 • As patients age, they may have a slower response to care, and this may affect the  
 16 approval of a trial of care.
- 17 • Because pediatric patients (under the age of 12) have not reached musculoskeletal  
 18 maturity, it may be necessary to modify the types of therapies approved as well as  
 19 shorten the initial trial of care.
- 20 • Complicating and/or co-morbid condition factors vary depending upon individual  
 21 patient characteristics, the nature of the condition/complaints, historical and  
 22 examination elements, and may require appropriate coordination of care and/or  
 23 more timely re-evaluation.

24  
 25 Health equity is the attainment of the highest level of health for all people, where everyone  
 26 has a fair and just opportunity to attain their optimal health. Factors that can impede health  
 27 equity include, but are not limited to, race, ethnicity, disability, sexual orientation, gender  
 28 identity, socioeconomic status, geography, and preferred language. Social Determinants of  
 29 Health (SDoH) are important influences on health equity status. SDoH are the conditions  
 30 in the environments where people are born, live, learn, work, play, worship, and age that  
 31 affect a wide range of health, functioning, and quality-of-life outcomes and risks. There  
 32 are typically five domains of SDoH: 1) Economic stability; 2) Education access and  
 33 quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5)  
 34 Social and community context. These barriers to health equity may impact health care  
 35 access, the patient presentation, clinical evaluations, treatment planning, and patient  
 36 outcomes which may in turn influence medical necessity considerations.

37  
 38 The following are examples of the factors CQEs consider when verifying the medical  
 39 necessity of rehabilitative services for musculoskeletal conditions and pain disorders.

### 1 **8.3.1 General Factors**

2 Multiple patient-specific historical and clinical findings may influence clinical decisions,  
3 such as but not limited to:

- 4 • Red flags
- 5 • Yellow flags (psychosocial factors)
- 6 • Co-morbid conditions (e.g., diabetes, inflammatory conditions, joint instability)
- 7 • Age (older or younger)
- 8 • Non-compliance with treatment and/or self-care recommendations
- 9 • Lack of response to appropriate care
- 10 • Lifestyle factors (e.g., smoking, diet, stress, deconditioning)
- 11 • Work and recreational activities
- 12 • Pre-operative/post-operative care
- 13 • Medication use (type and compliance)

#### 14 Nature of Complaint(s)

- 15 • Acute and severe symptoms
- 16 • Functional testing results that display severe disability/dysfunction
- 17 • Pain that radiates below the knee or elbow (for spinal conditions)

#### 18 History

- 19 • Trauma resulting in significant injury or functional deficits.
- 20 • Pre-existing pathologies/surgery(ies)
- 21 • Congenital anomalies (e.g., severe scoliosis)
- 22 • Recurring exacerbations
- 23 • Prior episodes (e.g., >3 for spinal conditions)
- 24 • Multiple new conditions which introduce concerns regarding the cause of these
- 25 conditions

#### 26 Examination

- 27 • Severe signs/findings
- 28 • Results from diagnostic testing that are likely to impact coordination of care and
- 29 response to care (e.g., fracture, joint instability, neurological deficits)

### 30 **Assessment of Red Flags**

31 At any time the patient is under care, the practitioner is responsible for seeking and  
32 recognizing signs and symptoms that require additional diagnostics, treatment/service,  
33 and/or referral. A careful and adequately comprehensive history and evaluation in addition  
34 to ongoing monitoring during the course of treatment is necessary to discover potential  
35 serious underlying conditions that may need urgent attention. Red flags can present

1 themselves at several points during the patient encounter and can appear in many different  
 2 forms. If a red flag is identified during a medical necessity review, the CQE should  
 3 communicate with the practitioner of services as soon as possible by telephone and/or  
 4 through standardized communication methods. When red flag is identified, the CQE may  
 5 inquire whether such red flag was identified and addressed by the practitioner, not approve  
 6 services and recommend returning the patient back to the referring healthcare practitioner  
 7 or referring the patient to other appropriate health care practitioner/specialist with the  
 8 measure of urgency as warranted by the history and clinical findings.

9  
 10 Important red flags and events as well as the points during the clinical encounter at which  
 11 they are likely to appear include but may not be limited to:

12  
 13 **Past or Current History**

- 14 • Personal or family history of cancer
- 15 • Current or recent urinary tract, respiratory tract, or other infection
- 16 • Anticoagulant therapy or blood clotting disorder
- 17 • Metabolic bone disorder (osteopenia and osteoporosis)
- 18 • Unintended weight loss
- 19 • Significant trauma sufficient to cause fracture or internal injury
- 20 • Unexplained dizziness or hearing loss
- 21 • Trauma with skin penetration
- 22 • Immunosuppression (AIDS/HIV/ARC)
- 23 • Intravenous drug abuse, alcoholism
- 24 • Prolonged corticosteroid use
- 25 • Previous adverse reaction to substances or other treatment modalities
- 26 • Use of substances or treatment which may contraindicate proposed services
- 27 • Uncontrolled health condition (e.g., diabetes, hypertension, asthma)

28  
 29 **Present Complaint**

- 30 • Writhing or cramping pain
- 31 • Precipitation by significant trauma
- 32 • Pain that is worse at night or not relieved by any position
- 33 • Suspicion of vascular/cerebrovascular compromise
- 34 • Symptom's indicative of progressive neurological disorder
- 35 • Unexplained dizziness or hearing loss
- 36 • Complaint inconsistent with reported mechanism of injury and/or evaluation  
 37 findings
- 38 • Signs of psychological distress

1 Physical Examination/Assessment

- 2 • Inability to reproduce symptoms of musculoskeletal diagnosis or complaints
- 3 • Fever, chills, or sweats without other obvious source
- 4 • New or recent neurologic deficit (e.g., special senses, peripheral sensory, motor,
- 5 language, and cognitive)
- 6 • Positive vascular screening tests (e.g., carotid stenosis, vertebrobasilar
- 7 insufficiency, abdominal aortic aneurysm)Abnormal vital signs
- 8 • Uncontrolled hypertension
- 9 • Signs of nutritional deficiency
- 10 • Signs of allergic reaction requiring immediate attention
- 11 • Surface lesions or infections in area to be treated
- 12 • Widespread or multiple contusions
- 13 • Unexplained severe tenderness or pain
- 14 • Signs of abuse/neglect
- 15 • Signs of psychological distress

16

17 Pattern of Symptoms Not Consistent with Benign Disorder

- 18 • Chest tightness, difficulty breathing, chest pain
- 19 • Headache of morbid proportion
- 20 • Rapidly progressive neurological deficit
- 21 • Significant, unexplained extremity weakness or clumsiness
- 22 • Change in bladder or bowel function
- 23 • New or worsening numbness or paresthesia
- 24 • Saddle anesthesia
- 25 • New or recent bilateral radiculopathy

26

27 Lack of Response to Appropriate Care

- 28 • History of consultation/care from a series of practitioners or a variety of health care
- 29 approaches without resolving the patient’s complaint
- 30 • Unsatisfactory clinical progress, especially when compared to apparently similar
- 31 cases or natural progression of the condition
- 32 • Signs and symptoms that do not fit the normal pattern and are not resolving

33

34 **Assessment of Yellow Flags**

35 When yellow flags are present, clinicians need to be vigilant for deviations from the normal

36 course of illness and recovery. Examples of yellow flags include depressive symptoms,

37 injuries still in litigation, signs, and symptoms not consistent with pain severity, and

38 behaviors incongruent with underlying anatomic and physiologic principles.



1 If a yellow flag is identified during a medical necessity review, the reviewer should  
 2 communicate with the practitioner of services as soon as possible by telephone and/or  
 3 through standardized communication methods. The CQE may inquire if the yellow flag  
 4 was identified, and, if so, how it was addressed. They may recommend returning the patient  
 5 back to the referring healthcare practitioner or referring the patient to other health care  
 6 practitioner/specialist as appropriate.

### 8 **Assessment of Historical Information**

9 The following factors are assessed in review and determination if the services are medically  
 10 necessary:

- 11 • The mechanism of onset and date of onset are congruent with the stated condition's  
 12 etiology.
- 13 • The patient's past medical history and response to care do not pose  
 14 contraindication(s) for the services submitted for review.
- 15 • The patient's past medical history of pertinent related and unrelated conditions does  
 16 not pose contraindication(s) for the services submitted for review.
- 17 • The patient's complaint(s) have component(s) that are likely to respond favorably  
 18 to services submitted for review.
- 19 • Provocative and palliative factors identified on examination indicate the presence  
 20 of a musculoskeletal condition as expected per diagnosis(es) or complaints, or as  
 21 consistent with other type of diagnosis(es).
- 22 • The patient's severity of limitations to activities of daily living (ADLs) are  
 23 appropriate and commensurate for the presence of the condition(s) or disorder(s).
- 24 • The quality, radiation, severity, and timing of pain are congruent with the  
 25 documented condition(s) or disorder(s).
- 26 • The patient's past medical history of having the same or similar condition(s)  
 27 indicates a favorable response to care.
- 28 • The absence or presence of co-morbid condition(s) may or may not present absolute  
 29 or relative contraindications to care.

### 31 **Assessment of Examination Findings**

- 32 • The exam procedures, level of complexity, and components are appropriate for the  
 33 patient's complaint(s) and historical findings.
- 34 • Objective palpatory, orthopedic, neurologic, and other physical examination  
 35 findings are current, clearly defined, qualified, and quantified, including the nature,  
 36 extent, severity, character, professional interpretation, and significance of the  
 37 finding(s) in relation to the patient's complaint(s) and differential diagnosis(es).
- 38 • Exam findings provide evidence justifying the condition(s) is/are likely to respond  
 39 favorably to services submitted for review.
- 40 • Exam findings provide a reasonable and reliable basis for the stated diagnosis(es).

- 1 • Exam findings provide a reasonable and reliable basis for treatment planning;  
2 accounting for variables such as age, sex, physical condition, occupational and  
3 recreational activities, co-morbid conditions, etc.
- 4 • The patient’s progress is being appropriately monitored each visit (as noted within  
5 daily chart notes and during periodic re-exams) to ensure that acceptable clinical  
6 progress is realized.

7

8 **Assessment of Treatment / Treatment Planning**

- 9 • Treatment dosage (frequency and duration of service) is appropriately correlated  
10 with the nature and severity of the subjective complaints, potential  
11 complications/barriers to recovery, and objective clinical evidence.
- 12 • Services that do not require the professional skills of a practitioner to perform or  
13 supervise are not medically necessary, even if they are performed or supervised by  
14 a Physical Therapist. Therefore, if the continuation of a patient’s care can proceed  
15 safely and effectively through a home exercise program or self-management  
16 program, services are not indicated or medically necessary.
- 17 • The use of passive modalities in the treatment of subacute or chronic conditions  
18 beyond the acute inflammatory response phase requires documentation of the  
19 anticipated benefit and condition-specific rationale in order to be considered  
20 medically necessary.
- 21 • The treatment plan includes the use of therapeutic procedures to address functional  
22 deficits and ADL restrictions.
- 23 • The set therapeutic goals are functionally oriented, realistic, measurable, and  
24 evidence based.
- 25 • The proposed/estimated date of release/discharge from treatment is noted.
- 26 • The treatment/therapies are appropriately correlated with the nature and severity of  
27 the patient’s condition(s) and set treatment goals.
- 28 • Functional Outcome Measures (FOM) demonstrate minimal clinically important  
29 difference (MCID) from baseline results through periodic reevaluations during the  
30 course of care. This is important in order to determine the need for continued care,  
31 the appropriate frequency of visits, estimated date of release from care, and if a  
32 change in the treatment plan or a referral to an appropriate health care  
33 practitioners/specialist is indicated.
- 34 • Home care, self-care, and active-care instructions are documented.
- 35 • Durable Medical Equipment (DME), supplies, appliances, and supports are  
36 provided when medically necessary and appropriately correlated with clinical  
37 findings and clinical evidence.

### 1 **8.3.2 Factors that Influence Adverse Determinations of Clinical Services (Partial** 2 **Approvals/Denials)**

3 Factors that influence adverse determinations of clinical services may include but are not  
 4 limited to these specific considerations and other guidelines and factors identified  
 5 elsewhere in this policy. Topics/factors covered elsewhere in this guideline are also  
 6 applicable in this section and may result in an adverse determination on medical necessity  
 7 review. To avoid redundancy, many of those factors have not been listed below.

#### 9 **Additional Factors Considered in Determination of Medical Necessity**

##### 10 **History / Complaints / Patient Reported Outcome Measures**

- 12 • The patient’s complaint(s) and/or symptom(s) are not clearly described
- 13 • There is poor correlation and/or a significant discrepancy between the complaint(s)  
 14 and/or symptom(s) as documented by the treating practitioner and as described by  
 15 the patient
- 16 • The patient’s complaint(s) and/or symptom(s) have not demonstrated clinically  
 17 significant improvement
- 18 • The nature and severity of the patient’s complaint(s) and/or symptom(s) are  
 19 insufficient to substantiate the medical necessity of any/all submitted services
- 20 • The patient has little or no pain as measured on a valid pain scale
- 21 • The patient has little or no functional deficits using a valid functional outcome  
 22 measure or as otherwise documented by the practitioner

##### 24 **Evaluation Findings**

- 25 • There is poor correlation and/or a significant discrepancy in any of the following:  
 26 ○ patient’s history  
 27 ○ subjective complaints  
 28 ○ objective findings  
 29 ○ diagnosis  
 30 ○ treatment plan
- 31 • The application of various exam findings to treatment decisions are not clearly  
 32 described or measured (e.g., severity, intensity, professional interpretation of  
 33 results, significance)
- 34 • The patient’s objective findings have not demonstrated clinically significant  
 35 improvement
- 36 • The objective findings are essentially normal or are insufficient to support the  
 37 medical necessity of any/all submitted services
- 38 • The submitted objective findings are insufficient due to any of, but not limited to,  
 39 the following reasons:  
 40 ○ old or outdated relative to the requested dates of service

- 1           ○ do not properly describe the patient’s current status
- 2           ○ do not substantiate the medical necessity of the current treatment plan do
- 3           not support the patient’s diagnosis/diagnoses do not correlate with the
- 4           patient’s subjective complaint(s) and/or symptom(s)
- 5       • Not all of the patient’s presenting complaints were properly examined
- 6       • The patient does not have any demonstrable functional deficits or impairments
- 7       • The patient has not made reasonable progress toward pre-clinical status or
- 8       functional outcomes under the initial treatment/services
- 9       • Clinically significant therapeutic progress is not evident through a review of the
- 10       submitted records; this may indicate that the patient has reached maximum
- 11       therapeutic benefit
- 12       • The patient is approaching or has reached maximum therapeutic benefit
- 13       • The patient’s exam findings have returned to pre-injury status or prior level of
- 14       function
- 15       • There is inaccurate reporting of clinical findings
- 16       • The exam performed is for any of the following:
- 17           ○ wellness
- 18           ○ pre-employment
- 19           ○ sports pre-participation
- 20       • The exam performed is non-standard and solely technique/protocol based

**Diagnosis**

- 23       • The diagnosis is not supported by one or more of the following:
- 24           ○ patient’s history (e.g., date/mechanism of onset)
- 25           ○ subjective complaints (e.g., nature and severity, location)
- 26           ○ objective findings (e.g., not clearly defined and/or quantified, not
- 27           professionally interpreted, significance not noted)

**Submitted Medical Records**

- 30       • The submitted records are insufficient to reliably verify pertinent clinical
- 31       information, such as (but not limited to):
- 32           ○ patient’s clinical health status
- 33           ○ the nature and severity of the patient’s complaint(s) and/or symptom(s)
- 34           ○ date/mechanism of onset
- 35           ○ objective findings
- 36           ○ diagnosis/diagnoses
- 37           ○ response to care
- 38           ○ functional deficits/limitations
- 39       • There are daily notes submitted for the same dates of service with different/altered
- 40       findings without an explanation

- 1 • There is evidence of duplicated or nearly duplicated records for the same patient
- 2 for different dates of service, or for different patients
- 3 • There is poor correlation and/or a significant discrepancy between the information
- 4 presented in the submitted records with the information presented during a verbal
- 5 communication between the reviewing CQE and treating practitioner
- 6 • The treatment time (in minutes) and/or the number of units used in the performance
- 7 of a timed service (e.g., modality, procedure) during each encounter/office visit was
- 8 not documented
- 9 • Some or all of the service(s) submitted for review are not documented as having
- 10 been performed in the daily treatment notes

### 11 **Treatment / Treatment Planning**

- 12 • The submitted records show that the nature and severity of the patient's
- 13 complaint(s) and/or symptom(s) require a limited, short trial of care in order to
- 14 monitor the patient's response to care and determine the efficacy of the current
- 15 treatment plan. This may include, but not limited to, any of the following:
- 16
  - 17 ○ significant trauma affecting function
  - 18 ○ acute/sub-acute stage of condition
  - 19 ○ moderate-to-severe or severe subjective and objective findings
  - 20 ○ possible neurological involvement
  - 21 ○ presence of co-morbidities that may significantly affect the treatment plan
  - 22 and/or the patient's response to care
- 23 • There is poor correlation of the treatment plan with the nature and severity of the
- 24 patient's complaint(s) and/or symptom(s), such as (but not limited to):
- 25
  - 26 ○ use of acute care protocols for chronic condition(s)
  - 27 ○ prolonged reliance on passive care
  - 28 ○ active care and reduction of passive care are not included in the treatment
  - 29 plan
  - 30 ○ inappropriate use of passive modalities in the plan of care
  - 31 ○ use of passive modalities as stand-alone treatments (which is rarely
  - 32 therapeutic) or as the sole treatment approach to the patient's condition(s)
- 33 • There is evidence from the submitted records that the patient's treatment can
- 34 proceed safely and effectively through a home exercise program or self-
- 35 management program
- 36 • The patient's function has improved, complaints and symptoms have decreased,
- 37 and patient requires less treatment (e.g., lesser units of services per office visit,
- 38 lesser frequency, and/or shorter total duration to discharge)
- 39 • The patient's symptoms and/or exam findings are mild and the patient's treatment
- 40 plan requires a lesser frequency (e.g., units of services, office visits per week)
- and/or total duration

- 1 • Therapeutic goals have not been documented. Goals should be measurable and
- 2 written in terms of function and include specific parameters
- 3 • Therapeutic goals have not been reassessed in a timely manner to determine if the
- 4 patient is making expected progress
- 5 • Failure to make progress or respond to care as documented within subjective
- 6 complaints, objective findings and/or functional outcome measures
- 7 • The patient’s condition(s) is/are not amenable to the proposed treatment plan
- 8 • Additional significant improvement cannot be reasonably expected by continued
- 9 treatment, therefore treatment must be changed or discontinued
- 10 • The patient has had ongoing care without any documented lasting therapeutic
- 11 benefits
- 12 • The condition requires an appropriate referral and/or coordination with other
- 13 appropriate health care services
- 14 • The patient is not complying with the treatment plan that includes lifestyle changes
- 15 to help reduce frequency and intensity of symptoms
- 16 • The patient is not adhering to treatment plan that includes medically necessary
- 17 frequency and intensity of services without documented extenuating circumstances
- 18 • The use of multiple passive modalities with the same or similar physiologic effects
- 19 to the identical region is considered redundant and not reasonable or medically
- 20 necessary
- 21 • Home care, self-care, and active-care instructions are not implemented or
- 22 documented in the submitted records
- 23 • Uncomplicated diagnoses do not require services beyond the initial treatment plan
- 24 before discharging the patient to active home/self-care (e.g., mild knee pain that
- 25 can be managed with a home exercise program)
- 26 • As symptoms and clinical findings improve the frequency of services (e.g., visits
- 27 per week/month) did not decrease. The submitted services do not or no longer
- 28 require the professional skills of the treating practitioner. The treatment plan is for
- 29 any of the following:
- 30 ○ preventive care
- 31 ○ elective/convenience/wellness care
- 32 ○ back school
- 33 ○ vocational rehabilitation or return to work programs
- 34 ○ work hardening programs
- 35 ○ routine educational, training, conditioning, return to sport, or fitness.
- 36 ○ non-covered condition
- 37 • There is duplication of services with other healthcare practitioners/specialties
- 38 • The treatment plan is not supported due to, but not limited to, any of the following
- 39 reasons:
- 40 ○ technique-/protocol-based instead of individualized and evidence based

- 1           ○ generic and not individualized for the patient’s specific needs
- 2           ○ does not correlate with the set therapeutic goals
- 3           ○ not supported in the clinical literature (e.g., proprietary, unproven)
- 4           ○ not considered evidence-based and/or professionally accepted

5

6 The treatment plan includes services that are considered not evidence-based, not widely  
 7 accepted, unproven and/or not medically necessary, inappropriate or unrelated to the  
 8 patient’s complaint(s) and/or diagnosis/diagnoses. (e.g., Low level laser therapy,  
 9 axial/spinal decompression, select forms of EMS such as microcurrent, H-wave. Also see  
 10 the *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133 – S)*  
 11 clinical practice guideline for complete list).

12

13 **Health and Safety**

- 14       • There are signs, symptoms and/or other pertinent information presented through the  
 15 patient’s history, exam findings, and/or response to care that require urgent  
 16 attention, further testing, and/or referral to and/or coordination with other  
 17 healthcare practitioners/specialists
- 18       • There is evidence of the presence of Yellow and/or Red Flags (See section on Red  
 19 and Yellow Flags above)
- 20       • There are historical, subjective, and/or objective findings which present as  
 21 contraindications for the plan of care

22

23 **8.3.3 Referral / Coordination of Services**

24 When a potential health and safety issue is identified, the CQE must communicate with the  
 25 practitioner of services as soon as possible by telephone and/or through standardized  
 26 communication methods to recommend returning the patient back to the referring health  
 27 care practitioner or referring the patient to other appropriate health care  
 28 practitioner/specialist with the measure of urgency as warranted by the history and clinical  
 29 findings. Such referral does not preclude coordinated cotreatment if / when applicable and  
 30 documented as such.

31

32 Clinical factors that may require referral or coordination of services include, but not limited  
 33 to:

- 34       • Symptoms worsening following treatment;
- 35       • Deteriorating condition (e.g., orthopedic or neurologic findings, function, etc.);
- 36       • Reoccurring exacerbations despite continued treatment;
- 37       • No progress despite treatment;
- 38       • Unexplained diagnostic findings (e.g., suspicion of fracture);
- 39       • Identification of red flags;

- 1 • Identification of co-morbid conditions that don't appear to have been addressed
- 2 previously that represent absolute contraindications to services;
- 3 • Constitutional signs and symptoms indicative of systemic condition (e.g.,
- 4 unintended weight loss of greater than 4.5 kg/10 lbs. over 6-month period);
- 5 • Inability to provoke symptoms with standard exam;
- 6 • Treatment needed outside of scope of practice.

7  
8 The Clinical Policy is reviewed and approved by the ASH Clinical Quality committees that  
9 are comprised of contracted network practitioners including practitioners of the same  
10 clinical discipline as the practitioners for whom compliance with the practices articulated  
11 in this this document is required. Guidelines are updated at least annually, or as new  
12 information is identified that result in material changes to one or more of these policies.

## 13 14 **9. EVIDENCE REVIEW**

15 There are several guidelines, systematic reviews, meta-analyses, and randomized  
16 controlled trials (RCTs) published that examine physical therapy (a variety of  
17 interventions) for various conditions and note effectiveness of physical rehabilitation,  
18 exercise, education, manual therapies (e.g., mobilization, manipulation, soft tissue  
19 mobilization), and other various modalities (Qaseem et al., 2020; Bricca et al., 2020;  
20 Raghava Neelapala et al., 2020; Taylor et al., 2007; Chou et al., 2016; Qaseem et al., 2017;  
21 Byström et al., 2013; Macedo et al., 2016; Saragiotto et al., 2016; Steffens et al., 2016; van  
22 Middelkoop et al., 2011; Logerstedt et al., 2010; Logerstedt et al., 2017; Logerstedt et al.,  
23 2018; Cibulka et al., 2017; Hurwitz et al., 2009; Delitto et al., 2012; Blanpied et al., 2017;  
24 BiDonde et al., 2019; Pollock et al., 2014; Yousefi-Nooraie et al., 2008; Chou et al., 2020;  
25 Skelly et al., 2018; Skelly et al., 2020; Jacobi et al., 2021; Mertens et al., 2022; Núñez-  
26 Cabaleiro et al., 2022; Schenk et al., 2022; Huang et al., 2022). Passive modalities, such as  
27 ultrasound, electric stimulation, traction, laser, and hot and cold packs, are often used in  
28 combination with manual therapies and exercise despite insufficient and/or inconclusive  
29 evidence for many conditions. Often methodologic flaws and heterogeneity of studies  
30 result in an inability to draw confirmatory conclusions.

31  
32 **Therapeutic Massage:** Few clinical trials have been undertaken to assess the effect of this  
33 modality alone in the treatment of specific medical conditions. Rehabilitation programs  
34 frequently combine massage therapy with one or more other treatment interventions. While  
35 there is scant literature regarding the efficacy of this treatment when used as the sole  
36 modality, massage therapy has been a part of physical therapy or chiropractic treatment  
37 plans for the management of musculoskeletal pain. As an example, for mechanical low  
38 back pain, the greatest effects of massage therapy are seen in short term relief of pain. The  
39 effects on function were less clear. These therapeutic effects tend to diminish in the longer  
40 term (Chou et al., 2016). Massage therapy was also noted as an effective treatment of acute  
41 post-operative pain (Chou et al., 2020) and chronic low back pain in the intermediate term



1 (Skelly et al., 2018). Slight functional improvements were noted in the intermediate term  
 2 for fibromyalgia using myofascial release massage (Skelly et al., 2018; Kundakci et al.,  
 3 2022).

#### 4 **9.1 Physical Therapy for Conditions Considered Unproven**

##### 5 **Sexual Dysfunction (unrelated to musculoskeletal or orthopedic condition)**

6 Female sexual dysfunction conditions can be classified as sexual desire disorders, sexual  
 7 arousal disorder, orgasmic disorder, or sexual pain disorders. Hypoactive sexual desire  
 8 disorder and sexual aversion disorder comprise the sexual desire disorders. ACOG (2019)  
 9 published a clinical management guideline on female sexual dysfunction. Conditions  
 10 included in this guideline include sexual desire disorders (e.g., hypoactive sexual desire  
 11 disorder and sexual aversion disorder), female sexual arousal disorder, female orgasmic  
 12 disorder, and sexual pain disorders with no muscular involvement (e.g., dyspareunia,  
 13 vaginismus). Physical therapy is not included in the recommendations in this guideline.  
 14

15  
 16 The European Urological Association published guidelines on male sexual dysfunction,  
 17 including erectile dysfunction and premature ejaculation. Physical therapy is not included  
 18 in the guidelines as a treatment for these conditions (Hatzimouratidis, et al., 2015).  
 19

##### 20 **Scoliosis**

21 Scoliosis, lateral curvature of the spine, is a structural alteration that occurs in a variety of  
 22 conditions. Progression of the curvature during periods of rapid growth can result in  
 23 significant deformity, which may be accompanied by cardiopulmonary compromise  
 24 (Schreiber et al., 2019; Scherl, 2016). Options for treatment of scoliosis include  
 25 observation, bracing, and surgery. Evidence is insufficient to demonstrate effectiveness of  
 26 physical therapy (scoliosis-specific exercises, (including the Schroth Method), chiropractic  
 27 treatment, electrical stimulation, or biofeedback to correct, improve or prevent further  
 28 curvature (Seleviciene et al., 2022; Santos et al., 2022; Fan et al., 2020; Schreiber et al.,  
 29 2019; Scherl, 2016; National Institutes of Health [NIH]/National Institute of Arthritis and  
 30 Musculoskeletal and Skin Disease [NIAMS], 2019; American Academy of Orthopedic  
 31 Surgeons [AAOS], 2019; Mehlman, 2020; Romano, et al., 2012). Evidence is insufficient  
 32 to demonstrate effectiveness of this treatment method to correct, improve or prevent further  
 33 curvature.  
 34

35 Scoliosis in itself is generally not predictive of pain or dysfunction. The clinical  
 36 presentation of scoliosis can vary greatly, ranging from minimal or no symptoms, to severe  
 37 pain and disability. The presence of scoliosis can result in chronic pain, radicular symptoms  
 38 and even restriction of lung capacity. However, most patients with scoliosis do not have  
 39 symptoms. Physical therapists should focus on treating the symptoms of the patient with  
 40 scoliosis as they would any other patient with back pain.

1 **9.2 Specific Physical Therapy Treatments Considered Unproven**  
 2 **Constraint-Induced Movement Therapy (CIMT)**

3 Constraint-induced movement therapy (CIMT) is a multi-faceted intervention that has been  
 4 proposed for neurological conditions that involve hemiparesis. CIMT is also referred to as  
 5 constraint-induced therapy or forced use therapy and is primarily provided by physical  
 6 therapists and occupational therapists. Several variations exist based on method and length  
 7 of restraint, and type and duration of therapy (e.g., environment and practitioner). The  
 8 therapy involves constraining the unaffected arm or hand with a sling, glove or mitt. CIMT  
 9 typically involves intensive individualized therapy with up to six–eight hours of therapy  
 10 provided per day. However, other forms of modified CIMT have been developed with less  
 11 therapy provided, but longer periods of restraint (Wolf, 2006). Veterans Affairs/Dept of  
 12 Defense (VA/DoD) published guidelines that have also been endorsed by American Heart  
 13 Association/American Stroke Association (AHA/ASA)—Clinical Practice Guideline for  
 14 the Management of Adult Stroke Rehabilitation Care (Bates, et al., 2005). The guidelines  
 15 note that, “Use of constraint-induced therapy should be considered for a select group of  
 16 patients—that is, patients with 20 degrees of wrist extension and 10 degrees of finger  
 17 extension, who have no sensory and cognitive deficits.” indicating a recommendation that  
 18 the intervention may be considered). The Royal College of Physicians/Intercollegiate  
 19 Stroke Working Party (United Kingdom) and the Ottawa Panel (2006) agree with these  
 20 recommendations.

21  
 22 CIMT has demonstrated inconsistent effectiveness for treatment of patients post-stroke  
 23 (Abdullahi et al., 2020; Pulman et al., 2013; McIntyre et al., 2012; Corbetta et al., 2010;  
 24 Sirtori et al., 2009; Abdullahi et al., 2021; Alaca and Ocal, 2022; Gulrandhe et al., 2023).  
 25 Future randomized controlled trials need to have accurate characteristics in terms of  
 26 methodological quality, larger samples, longer follow up, reliable and relevant measure  
 27 and report of adverse events. Some evidence demonstrates that modified CIMT could  
 28 reduce the level of disability, improve the ability to use the paretic upper extremity, and  
 29 enhance spontaneity during movement time, but evidence is still limited about the  
 30 effectiveness of modified CIMT in kinematic analysis (Pollock et al., 2014; Shi et al.,  
 31 2011). Research suggests that modified CIMT and intensive CIMT produce similar results  
 32 (Peurala et al., 2012).

33  
 34 CIMT has also been used for the treatment of children with cerebral palsy (CP). Research  
 35 is not conclusive with regards to the effectiveness of CIMT for this population; however  
 36 there appears to be modest evidence to support its use in a modified format (Martínez-  
 37 Costa and Cabeza, 2020; Novak et al., 2020; Sakzewski et al., 2009, 2014; Hoare et al.,  
 38 2007; Chen et al., 2014; Chiu and Ada, 2016; Hoare et al., 2019; Martínez-Costa Montero  
 39 et al., 2020; Walker et al., 2022; Dionisio and Terrill, 2022; Jackman et al., 2022; Baker et  
 40 al., 2022; Gulrandhe et al., 2023). Further research using adequately powered RCTs  
 41 [randomized controlled trials], rigorous methodology and valid, reliable outcome measures

1 is essential to provide higher level support of the effectiveness of CIMT for children with  
2 hemiplegic cerebral palsy.

3  
4 **Intensive Model of Therapy (IMOT) Programs**

5 Refer to *Intensive Model of Therapy (CPG 286 – S) clinical practice guideline* for more  
6 information.

7  
8 **Dry Hydrotherapy**

9 Dry hydrotherapy, also referred to as aquamassage, water massage, or hydromassage, is a  
10 treatment that incorporates water with the intent of providing therapeutic massage. The  
11 treatment is generally provided in chiropractor or physical therapy offices. There are  
12 several dry hydrotherapy devices available that provide this treatment, including the  
13 following:

- 14 • Aqua Massage® (AMI Inc., Mystic, CT)
- 15 • AquaMED® (JTL Enterprises, Inc., Clearwater, FL)
- 16 • H2OMassage System™ (H2OMassage Systems, Winnipeg, MB, Canada)
- 17 • Hydrotherapy Tables (Sidmar Manufacturing, Inc., Princeton, MN)

18  
19 Proponents of dry hydrotherapy maintain that it can be used in lieu of certain conventional  
20 physical medicine therapeutic modalities and procedures, such as heat packs, wet  
21 hydrotherapy, massage, and soft tissue manipulation. The assertions that have been made  
22 by manufacturers of this device at their websites have not yet been proven. No published  
23 studies or information regarding dry hydrotherapy devices or dry hydrotherapy treatment  
24 were identified in the peer-reviewed scientific literature. In the absence of peer- reviewed  
25 literature demonstrating the effectiveness of dry hydrotherapy and in the absence of  
26 comparison to currently accepted treatment modalities, no definitive conclusions can be  
27 drawn regarding the clinical benefits of this treatment.

28  
29 **Non-invasive Interactive Neurostimulation (e.g., InterX®)**

30 Refer to *Non-invasive Interactive Neurostimulation (InterX®) (CPG 277 – S) clinical*  
31 *practice guideline* for more information.

32  
33 **Microcurrent Electrical Nerve Stimulation (MENS)**

34 For more information, see Electric Stimulation for Pain, Swelling and Function in the  
35 Clinic Setting (CPG 272 – S) clinical practice guideline.

36  
37 **H-WAVE®**

38 Refer to *H-WAVE® Electrical Stimulation (CPG 269 – S) clinical practice guideline* for  
39 more information.

1 **Spinal Manipulation for the Treatment of Non-Musculoskeletal Conditions and**  
 2 **Related Disorders**

3 Refer to *Spinal Manipulative Therapy for Non-Musculoskeletal Conditions and Related*  
 4 *Disorders (CPG 119 – S) clinical practice guideline* for more information.

6 **Equestrian Therapy (e.g., hippotherapy)**

7 Equestrian therapy, also known as hippotherapy, is proposed to offer a person with a  
 8 disability a means of physical activity that aids in improving balance, posture, coordination,  
 9 the development of a positive attitude and a sense of accomplishment. It is proposed for  
 10 treatment of several conditions including autism spectrum disorders and cerebral palsy.  
 11 There is insufficient published evidence regarding the effects of this therapy on individuals  
 12 with impaired physical function resulting from illness, injury, congenital defect or surgery  
 13 (De Guindos-Sanchez et al., 2020; De Miguel et al., 2018; Marquez et al., 2020; White et  
 14 al., 2020; Santos de Assis et al., 2022; Pantera et al., 2022; Pérez-Gómez et al., 2022;  
 15 Heussen and Häusler, 2022; Prieto et al., 2022). It is noted that most studies are limited by  
 16 methodological weaknesses.

18 **MEDEK Therapy**

19 Refer to *MEDEK Therapy (CPG 276 – S) clinical practice guideline* for more information.

21 **The Interactive Metronome Program**

22 Interactive Metronome® (IM) is purported to be an assessment and training tool that  
 23 measures and improves Neurotiming, or the synchronization of neural impulses within key  
 24 brain networks for cognitive, communicative, sensory and motor performance. It is  
 25 designed to improve processing speed, focus, and coordination. Patients wear headphones  
 26 and match a beat using a hand or foot sensor along with visual and auditory feedback. The  
 27 IM program has been promoted as a treatment for children with attention-deficit  
 28 hyperactivity disorder (ADHD) and for other special needs children to increase  
 29 concentration, focus, and coordination. It has also been promoted to improve athletic  
 30 performance, to assess and improve academic performance of normal children, and to  
 31 improve children's performance in the arts (e.g., dance, music, theater, creative arts).  
 32 Additionally, it has been implemented as part of a therapy program for patients with  
 33 balance disorders, cerebrovascular accident, limb amputation, multiple sclerosis,  
 34 Parkinson's disease, and traumatic brain injury. However, based on peer-reviewed  
 35 literature, evidence is insufficient to support effectiveness of the IM program. Well-  
 36 designed clinical studies are needed to determine the effectiveness of the IM program and  
 37 whether a clinically significant improvement is achieved.

39 **Taping/Elastic therapeutic tape (e.g., Kinesio™ tape, Spidertech™ tape)**

40 Refer to *Strapping and Taping (CPG 143 – S) clinical practice guideline* for more  
 41 information.

1 **Dry Needling**  
 2 Refer to *Dry Needling (CPG 178 – S) clinical practice guideline* for more information.

3  
 4 **Laser Therapy (LT)**  
 5 Refer to *Laser Therapy (LT) (CPG 30 – S) clinical practice guideline* for more information.

6  
 7 **Vertebral Axial Decompression Therapy and Devices**  
 8 Refer to *Axial/Spinal Decompression Therapy (CPG 83 – S) clinical practice guideline* for  
 9 more information.

10  
 11 **10. CODING/BILLING INFORMATION**

- 12 **Note:**  
 13 1) This list of codes may not be all-inclusive.  
 14 2) Deleted codes and codes which are not effective at the time the service is rendered  
 15 may not be eligible for reimbursement.

16  
 17 **Covered when medically necessary:**

CPT®* Code	CPT® Code Description
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
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
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

CPT®* Code	CPT® Code Description
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, 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)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation

CPT®* Code	CPT® Code Description
	with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
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
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes

<b>CPT®* Code</b>	<b>CPT® Code Description</b>
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

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<b>HCPCS Code</b>	<b>HCPCS Code Description</b>
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)
S9131	Physical therapy; in the home, per diem

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**Training in Nature/Not Medically Necessary/Not Covered:**

<b>CPT®* Code</b>	<b>CPT® Code Description</b>
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
97169	Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family
97170	Athletic training evaluation, moderate complexity, requiring these components: A medical history and physical activity profile with 1-2 comorbidities that affect physical activity. An examination of



<b>CPT®* Code</b>	<b>CPT® Code Description</b>
	affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97171	Athletic training evaluation, high complexity, requiring these components: A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; Clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97172	Re-evaluation of athletic training established plan of care requiring these components: An assessment of patient’s current functional status when there is a documented change, and A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)

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<b>HCPCS Code</b>	<b>HCPCS Code Description</b>
S8990	Physical or manipulative therapy performed for maintenance rather than restoration

S9117	Back school, per visit
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Unproven and not covered when used to report constraint-induced movement therapy or dry hydrotherapy/aquamassage/hydromassage, equestrian therapy (e.g., hippotherapy), elastic therapeutic tape/taping, low-level laser therapy or vertebral axial decompression:

HCPCS Code	HCPCS Code Description
S8940	Equestrian/hippotherapy, per session
S8948	Application of a modality (requiring constant practitioner attendance) to one or more areas, low-level laser; each 15 minutes
S9090	Vertebral axial decompression, per session
E0744	Neuromuscular stimulator for scoliosis

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