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

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Product: **Specialty**

This American Specialty Health – Specialty (ASH) Clinical Practice Guideline (CPG) provides a comprehensive overview of ASH Physical Therapy Guidelines; including the following:

- Verifying that services submitted for an initial trial of care meet the definition of Medical Necessity;
- Verifying that services submitted for continuing care meet the definition of Medical Necessity;
- Denial of coverage of services submitted for not meeting the definition of Medical Necessity; and
- Identifying cases suggesting the need for referral or coordination of care.

Please note: Client exceptions to ASH clinical practice guidelines can be found in the applicable client summary.

This policy is not intended to convey benefit coverage but rather provides a description of the full qualifications and scope of abilities, based on educational background, of physical therapists within the health care system and community. This policy also describes appropriate use of physical therapy codes and intended purpose.

The Guide to Physical Therapist Practice, published by the APTA (2003), supports this guideline in all areas of physical therapy practice.

Other supporting resources and documentation include the following:

- CR 1: Credentialing Program
- UM 1: Clinical Services Program
- UM 2: Medical Necessity Review
- UM 8: Medical Necessity Definition
- CPG 2: Practice Parameters and Review Criteria
- CPG 3: Quality Patient Management
- CPG 5: Selected List of References – Physical and Occupational Therapy
- CPG 12: Medical Necessity Decision Assist Guideline for Musculoskeletal Conditions and Somatic / Neuropathic Pain Disorders
- CPG 14: Clinical Guidelines and Criteria
- CPG 30: Cold/Cool Laser-Low Laser Light Therapy (LLLT)

- CPG 83: Axial Decompression Therapy (aka Decompression Therapy or Spinal Decompression Therapy)
- CPG 110: Medical Record Documentation
- CPG 111: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations
- CPG 112: Exercise Therapy for Treatment of Chronic Non-Specific Low Back Pain
- CPG 113: Exercise Therapy for Treatment of Neck Pain
- CPG 115: Spinal Manipulation for Treatment of Acute, Sub-Acute, and Chronic Low Back Pain
- CPG 116: Spinal Manipulation for Treatment of Acute, Sub-Acute, and Chronic Neck Pain
- CPG 117: Spinal Manipulation for Treatment of Acute, Sub-Acute, and Chronic Thoracic Spine Pain
- CPG 132: Spinal Manipulation for Non-Neuromuscular Conditions
- CPG 121: Passive Physiotherapy Modalities
- CPG 144: Prosthetics Training and Evaluation
- 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)

GENERAL BACKGROUND

As stated in the Guide to Physical Therapist Practice (2003), physical therapy is a health profession whose primary purpose is the promotion of optimal health and function. As such, access to physical therapy services is necessary for health care consumers in order to optimize activity and participation in society. Physical therapy services reduce disability and clinical cost by reducing the need for services of greater expense, greater risk, or both to the patient. Physical therapists provide services to patients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes. In the context of the model of disablement (on which the Guide to Physical Therapist Practice is based), impairment is defined as the loss or abnormality of anatomical, physiological, mental, or psychological structure or function; *functional limitation* is defined as restriction of the ability to perform, at the level of the whole person, a physical action, task, or activity in an efficient, typically expected, or competent manner; and *disability* is defined as the inability to perform or a limitation in the performance of actions, tasks, and activities usually expected in specific social roles that are customary for the individual or expected

for the person's status or role in a specific sociocultural context and physical environment.

A physical therapy clinical diagnosis differs from a medical diagnosis. Physical therapists develop clinical diagnosis and manage movement dysfunction and enhance physical and functional abilities for movement disorders related to impairments of the musculoskeletal, cardiovascular/pulmonary, neuromuscular and integumentary systems. Physical therapists restore, maintain, and promote optimal physical function as well as optimal wellness, fitness, and quality of life as it relates to movement and health. Physical therapists also prevent the onset, symptoms and progression of impairments, functional limitations and disabilities that may result from diseases, disorders, conditions or injuries. Physical therapists are licensed health care professionals. Qualification for licensure includes passing the National Physical Therapy Exam (NPTE), administered by the Federation of State Boards of Physical Therapy. Another important qualification for licensure is graduation from a physical therapy education program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) or a program that is deemed substantially equivalent to a CAPTE accredited program.

The scope of this physical therapy policy does not indicate benefit coverage but rather describes services provided by physical therapists. Physical therapy is limited to the care and services provided by or under the direction and supervision of a physical therapist.

Physical Therapy Examination/Physical Therapy Evaluation

Physical therapists perform the patient management elements of examination, evaluation, diagnosis and prognosis. A *physical therapy examination* is the comprehensive screening and specific testing process that leads to physical therapy diagnostic classification or, as appropriate, referral to another health care practitioner. Examination includes patient history, systems review, and tests and measures. A *physical therapy evaluation* is the clinical judgment made by the physical therapist based on data gathered during the examination. Examining (history, system review and tests and measures) individuals with impairment, functional limitation, and disability or other health-related conditions is necessary in order to determine a physical therapy diagnosis, prognosis, and intervention. Examination tests and measures may include the following (these elements should be represented and provided as physical therapy only when they are performed by a licensed physical therapist):

- Aerobic capacity/endurance;
- Anthropometric characteristics;
- Arousal, attention, and cognition;
- Assistive and adaptive devices;
- Circulation (arterial, venous, lymphatic);
- Cranial and peripheral nerve integrity;
- Environmental, home, and work (job/school/play) barriers;

- Ergonomics and body mechanics;
- Gait, locomotion, and balance;
- Integumentary integrity;
- Joint integrity and mobility;
- Motor function (motor control and motor learning);
- Muscle performance (including strength, power, and endurance);
- Neuromotor development and sensory integration;
- Orthotic, protective, and supportive devices;
- Pain;
- Posture;
- Prosthetic requirements;
- Range of motion (including muscle length);
- Reflex integrity;
- Self-care and home management (including activities of daily living and instrumental activities of daily living);
- Sensory integrity;
- Ventilation, and respiration/gas exchange; and
- Work (job/school/play), community, leisure integration or reintegration (including instrumental activities of daily living)

The terms examination and evaluation can be combined to define the CPT physical therapy evaluation code 97001.

Physical Therapy Intervention

Physical therapy interventions are provided by or under the direction and supervision of licensed physical therapists in accordance with American Physical Therapy Association positions, policies, standards, codes, and guidelines, and applicable state laws. A *physical therapy intervention* is the purposeful interaction of the physical therapist with the patient and, when appropriate, with other individuals involved in patient care, using various physical therapy procedures and techniques to produce changes in the condition that are consistent with the diagnosis and prognosis. Physical therapy interventions consist of coordination, communication, and documentation; patient-related and family/caregiver instruction; and procedural interventions. Physical therapists aim to alleviate impairment and functional limitation by designing, implementing, and modifying therapeutic interventions. Other physical therapy interventions include, but are not limited to:

- Therapeutic exercise;
- Functional training in self-care and home management including activities of daily living (ADL) and instrumental activities of daily living (IADL);
- Functional training in work (job/school/play) and community and leisure integration or reintegration activities including IADL, work hardening, and work conditioning;

- Manual therapy techniques (including mobilization/manipulation);
- Prescription, application, and, as appropriate, fabrication of devices and equipment (assistive, adaptive, orthotic, protective, supportive, and prosthetic);
- Airway clearance techniques;
- Integumentary repair and protection techniques;
- Electrotherapeutic modalities; and
- Physical agents and mechanical modalities.

Credentialed physical therapists are expected to provide evidence-based services to decrease disability, improve function and independence, prevent illness, promote wellness and restore quality of life to the patients they serve; including the promotion and maintenance of health, fitness, and quality of life in all age populations. Physical therapists identify risk factors and behaviors that may impede optimal functioning. Physical therapists are involved in wellness initiatives, including health promotion and education that stimulate the public to engage in positive health behaviors. They provide preventive care that forestalls or prevents functional decline and the need for more intense care. As an independent service for a healthy member without a health condition or injury, physical therapy is not considered medically necessary.

Physical therapists engage in consultation, education, and research. Educating patients is one of the most important aspects of physical therapy services. Physical therapists are expected to engage in continuing education to ensure they are utilizing the most current, evidence-based treatment approaches and interventions. They are also involved in consulting with other professions to educate on what physical therapists can do to improve treatment results and costs within a collaborative model. Lastly, many physical therapists are performing clinical research to assist in the determination of improved patient care and outcomes.

MEDICAL NECESSITY

ASH considers physical therapy medically necessary when care delivered is appropriately documented and meets the ASH Medical Necessity definition and the member's benefit contract. Medically necessary physical therapy services will be delivered to significantly relieve pain, improve, develop or restore physical functions lost or impaired, and prevent further disability as a result of a disease, injury, congenital defect, or surgical procedure. Medically necessary physical therapy services are individualized and comprehensive, and are provided through the continuum of life and across all treatment settings. Medically necessary physical therapy services are provided by or under the direction and supervision of a licensed physical therapist consistent with the jurisdictional scope of practice and qualifications, and according to the needs of the patient. Physical therapy, as part of an individual's health care, is considered medically necessary as determined by the licensed physical therapist based on the results of a physical therapy evaluation and

when provided for the purpose of preventing, minimizing, or eliminating impairments, activity limitations, or participation restrictions.

Physical therapy is delivered throughout the episode of care by the physical therapist or under his or her direction and supervision. Physical therapy requires the knowledge, clinical judgment, and abilities of the therapist; takes into consideration the potential benefits and harms to the patient; and is not provided exclusively for the convenience of the patient. Physical therapy is provided using evidence of effectiveness and applicable physical therapy standards of practice and is considered medically necessary if the type, amount, frequency and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals and is verified as medically necessary by ASH:

- To improve function;
- Minimize loss of function; or
- Decrease risk of injury and disease.

Medically necessary physical therapy services must be restorative or for the purpose of designing and teaching a home exercise program for the patient to carry out at home after discharge from physical therapy to maintain or improve level of function. Many patients with neuromuscular, musculoskeletal or other movement impairment may experience improvement when following a home treatment program prescribed by their physical therapist. This is also true for patients with cardiopulmonary and integumentary conditions. Home treatment programs may include:

- Lifestyle behavioral recommendations;
- Splinting, supporting or wrapping; and
- Self-monitored, graded exercise therapy that does not require professional or medical supervision.

Medically necessary physical therapy services must also relate to a written treatment plan of care and be of a level of complexity that requires the judgment, knowledge and skills of a physical therapist to perform and/or supervise the services. The plan of care for medically necessary physical therapy services is established by a licensed physical therapist. The amount, frequency and duration of the physical therapy services must be reasonable (within regional norms and commonly accepted practice patterns); the services must be considered appropriate and needed for the treatment of the condition and must not be palliative in nature. Thus, once therapeutic benefit has been achieved, or a home exercise program could be used for further gains without the need for skilled physical therapy, continuing supervised physical therapy is not considered medically necessary. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. During the last visits for rehabilitative treatment, it may be reasonable and medically necessary for the physical therapist to develop a maintenance program, and instruct the patient, family member(s) or

caregiver(s) in carrying out the maintenance program. Therapy performed repetitively to maintain a level of function is typically not eligible for reimbursement. Maintenance care for persons whose condition is neither regressing nor improving is typically not considered medically necessary. Physical therapy services for asymptomatic persons or in persons without an identifiable clinical condition are also not considered medically necessary. Duplicate therapy (therapy that provides essentially redundant clinical effect) is not considered medically necessary. When individuals are receiving physical, occupational, or speech therapy concurrently, each therapist 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.

MODALITIES AND PROCEDURES

The American Medical Association (AMA) Current Procedural Terminology (CPT) manual 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" (AMA, 2011). 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.

Examples of supervised modalities include application of:

- Hot or cold packs,
- Mechanical traction,
- Unattended electrical stimulation (i.e. for pain relief),
- Vasopneumatic devices,
- Whirlpool,
- Paraffin bath,
- Diathermy, and
- Ultraviolet or infrared light.

Examples of modalities that require constant attendance include:

- Contrast baths,
- Ultrasound,
- Attended electrical stimulation (i.e. NMES), and
- Iontophoresis.

Passive modalities are most effective during the acute phase of treatment, since they are typically directed at reducing pain, inflammation, and swelling. They may also be utilized

during the acute phase of the exacerbation of a chronic condition. Passive modalities are rarely beneficial alone and are most effective when performed as part of a comprehensive treatment approach. Some improvement should be seen within three visits. After one or two weeks, the clinical effectiveness of passive modalities begins to decline significantly. In some situations, passive modalities may be indicated for up to one or two months as part of comprehensive physical therapy program. The need for passive modalities beyond two weeks should be objectively documented in the clinical record. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

The AMA CPT manual defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function" (AMA, 2011). Examples of therapeutic procedures include therapeutic exercise to develop strength and endurance, range of motion and flexibility; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; aquatic therapy with therapeutic exercises; gait training (including stairs); and manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction); or therapeutic activities using dynamic activities to improve functional performance (direct one-on-one patient contact by the practitioner).

Active therapeutic procedures are typically started as swelling, pain, and inflammation are reduced. The need for stabilization and support is replaced by the need for increased range of motion and restoration of function. Active care elements include increasing range of motion, strengthening primary and secondary stabilizers of a given region, and increasing the endurance capability of the muscles. Care focuses on active participation of the patient in their exercise program. Gait training, muscle strengthening, and progressive resistive exercises are considered active procedures. In general, patients should progress from active procedures to a home exercise program.

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

Hydrotherapy/Whirlpool/Hubbard Tank

These modalities involve supervised use of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds e.g., ulcers, skin conditions. More specifically, Hubbard tank involves a full-body immersion tank for treating severely burned, debilitated and/or neurologically impaired individuals. Hydrotherapy is considered medically necessary for pain relief, muscle relaxation and improvement of movement for persons with musculoskeletal conditions. It is also considered medically necessary for wound care (cleansing and debridement). It is not appropriate to utilize

more than one hydrotherapy modality on the same day. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Fluidotherapy®

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

Vasopneumatic Devices

These special devices apply pressure for swelling/edema reduction, either after an acute injury, following a surgical procedure, due to lymphedema, or due to pathology such as venous insufficiency. Education sessions for home use are considered medically necessary (up to two sessions).

Hot/Cold Packs

Hot packs increase blood flow, relieve pain and increase movement; cold packs decrease blood flow to an area for pain and swelling reduction and are typically used in the acute phase of injury or in the acute phase of an exacerbation. They are considered medically necessary for painful musculoskeletal conditions and acute injury. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Paraffin Bath

This modality uses hot wax for application of heat. It is indicated for use to relieve pain and increase range of motion of extremities (typically wrists and hands) due to chronic joint problems or post-surgical scenarios. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Mechanical Traction

This device provides a mechanical pull on the spine (cervical or lumbar) to relieve pain, spasm, and nerve root compression. For more information, see ASH policies Passive Physiotherapy Modalities - CPG 121 – S and Axial Decompression Therapy (aka Decompression Therapy or Spinal Decompression Therapy) – CPG 83 – S.

Infrared Light Therapy

This dry heat lamp is used to increase circulation to relieve muscle spasm. Other heating modalities are considered superior to infrared lamps. Infrared may also include low power laser or light therapy that utilizes laser or LED to treat damaged tissues. This does

not refer to Anodyne® Therapy System. For more information, see ASH policies Passive Physiotherapy Modalities - CPG 121 – S and Cold/Cool Laser-Low Laser Light Therapy (LLLT) – CPG 30 – S.

Electrical Stimulation
Electrical stimulation is used in different variations to relieve pain, reduce swelling, heal wounds, and improve muscle function. Functional electric stimulation is considered medically necessary for muscle re-education (to improve muscle contraction) in the earlier phases of rehabilitation. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Iontophoresis
Electric current used to transfer certain chemicals (medications) into body tissues. Use to treat inflammatory conditions, such as plantar fasciitis and lateral epicondylitis.

Contrast Baths
This modality is the application of alternative hot and cold baths and is typically used to treat extremities with subacute swelling or CRPS. Contrast baths assist with hypersensitivity reduction and swelling reduction.

Ultrasound
This modality provides deep heating through high frequency sound wave application. Non-thermal applications are also possible using the pulsed option. Ultrasound is commonly used to treat many soft tissue conditions that require deep heating or micromassage to a localized area to relieve pain and improve healing. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Diathermy (e.g., shortwave)
This modality utilizes high frequency magnetic and electrical current to provide deep heating to larger joints and soft tissue structures for pain relief, increased healing, and muscle spasm reduction. Microwave diathermy presents a negative benefit:risk ratio and is not recommended. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Therapeutic Exercises
This procedure includes instruction, feedback, and supervision of a person in an exercise program for their condition. The purpose is to increase/maintain flexibility and muscle strength. Therapeutic exercise is performed with a patient either actively, active-assisted, or passively. It is considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury. Note: Exercising done subsequently by the member without a physician or therapist present and supervising would not be covered. For more information, see ASH policy Exercise

Therapy for Treatment of Chronic Non-Specific Low Back Pain - CPG 112 – S and Exercise Therapy for Treatment of Neck Pain - CPG 113 – S.

Neuromuscular Reeducation

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who has reduced balance, strength, functional capacity or mobility which has resulted from disease, injury, or surgery. The goal is to develop conscious control of individual muscles and awareness of position of extremities. The procedure may be considered medically necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident and systemic neurological disease.

Aquatic Therapy

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

Gait Training

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

Massage Therapy

Massage involves manual techniques that include applying fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands. These techniques affect the musculoskeletal, circulatory-lymphatic, nervous, and other systems of the body with the intent of improving a person's well being or health. The most widely used forms of basic massage therapy include Swedish massage, deep-tissue massage, sports massage, neuromuscular massage, and manual lymph drainage. Massage therapy may be considered medically necessary in combination with another therapeutic procedure or activity on the same day, when designed to restore muscle function, reduce

edema, improve joint motion, or for relief of muscle spasm, and determined not duplicative to other modalities/procedures.

Soft Tissue Mobilization

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

Joint Mobilization/Manipulation

Joint mobilization and manipulation is utilized to reduce pain and increase joint mobility. Most often mobilizations are indicated for extremity and spine conditions, while manipulation may be more generally indicated for spinal conditions. For more information, see ASH policies Spinal Manipulation for Treatment of Acute, Sub-Acute, and Chronic Low Back Pain - CPG 115 - S, Spinal Manipulation for Treatment of Acute and Chronic Neck Pain - CPG 116 - S, Spinal Manipulation for Treatment of Acute, Sub-Acute, and Chronic Thoracic Spine Pain - CPG 117 - S, and Spinal Manipulative Therapy for Non-Neuromusculoskeletal Conditions - CPG 119 – S.

Therapeutic Activities

This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the professional skills of a practitioner and are designed to address a specific functional need of the member. This intervention may be appropriate after a patient has completed exercises focused on strengthening and range of motion but need to be progressed to more function-based activities. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

Activities of Daily Living (ADL) Training

Training of impaired individuals in essential activities of daily living and self care activities including: bathing; feeding; preparing meals; toileting; dressing; walking; making a bed; and transferring from bed to chair, wheelchair or walker. This procedure is considered medically necessary to enable the member to perform essential activities of daily living related to the patient's health and hygiene, within or outside the home, and with minimal or no assistance from others. Services provided concurrently by physical

therapists and occupational therapists may be considered medically necessary if there are separate and distinct functional goals.

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

Orthotic Training
Training and re-education with braces and/or splints (orthotics). For more information, see ASH policy Orthotic Training and Evaluation - CPG 152 – S.

Prosthetic Checkout
These assessments are considered medically necessary when a device is newly issued or there is a modification or re-issue of the device. These assessments are considered medically necessary when a member experiences loss of function directly related to the orthotic or prosthetic device (e.g., pain, skin breakdown, or falls). This is usually completed in 1-2 sessions. For more information, see ASH policy Prosthetics Training and Evaluation - CPG 144 – S.

Prosthetic Training
Training and re-education with prosthetics devices. Considered medically necessary for persons with a medically necessary prosthetic. Periodic return visits beyond the third month may be necessary. For more information, see ASH policy Prosthetics Training and Evaluation - CPG 144 – S.

Wheelchair Management Training
This procedure is considered medically necessary only when it is part of an active treatment plan directed at a specific goal. The member must have the capacity to learn from instructions. Typically, three (3) sessions are adequate. For more information, see ASH policy Wheelchair Management – CPG 148 – S.

Certain physical medicine modalities and therapeutic procedures are considered duplicative in nature and it would be inappropriate to perform or bill for these services during the same session, such as:

- Functional activities and ADLs;
- More than one deep heating modality;
- Massage therapy and myofascial release;

- Orthotics training and prosthetic training; and
- Whirlpool and Hubbard tank.

The medical necessity of neuromuscular reeducation, therapeutic exercises, and/or therapeutic activities, performed on the same day, must be documented in the medical record.

Only one heat modality would be considered medically necessary during the same treatment session, with the exception of use of one form of superficial heat and one form of deep heat (i.e. ultrasound or diathermy and hot packs). Use of two forms of deep or superficial heat would not be acceptable.

Active Wound Care Management

The AMA CPT manual defines active wound care procedures as those procedures "performed to remove devitalized tissue and/or necrotic tissue and promote healing" (AMA, 2011). The practitioner is required to have direct one-on-one contact with the patient. Examples of active wound care management include debridement of an open wound, including topical application; use of whirlpool or other modalities; and negative pressure wound therapy. For more information, see ASH policy Wound Care – CPG 156 – S.

Electromyography (EMG) and Nerve Conduction Velocity (NCV) Tests

According to the AMA CPT manual "Needle electromyographic procedures include the interpretation of electrical waveforms measured by equipment that produces both visible and audible components of electrical signals recorded from the muscle(s) studied by the needle electrode" (AMA, 2011). For nerve conduction testing, "motor nerve conduction study recordings must be made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings must be made from electrodes placed directly over the specific nerve to be tested." Waveforms must be reviewed on site in real-time. Reports must be prepared on site by the examiner and consist of the work product of the interpretation of numerous test results. EMG and NCV testing is only covered if provided by a qualified health care professional or physician. Physical therapists who are board certified by the APTA are considered qualified health professionals. State licensure rules and regulations apply. For more information, see ASH policy Electrodiagnostic Testing – CPG 129 – S.

Lymphedema Management

For more information, see ASH policy Lymphedema – CPG 157 – S.

The following interventions are not currently considered medically necessary:

- The Interactive Metronome Program: There is insufficient evidence to support its effectiveness.

- Kinesio Taping/Taping: The clinical value of Kinesio taping/taping for back pain, back-related conditions and radiculopathies, lower extremity spasticity, meralgia paresthetica, post-operative subacromial decompression, wrist injury, and prevention of ankle sprains has not been established, and thus is considered investigational. For more information, see ASH policy Strapping and Taping – CPG 143 – S.
- MEDEK Therapy: The clinical value has not been established.
- Hands-Free Ultrasound: This modality is considered experimental and investigational.
- Anodyne® Therapy System: Clinical effectiveness is inconclusive and thus is considered experimental and investigational.
- Constraint-induced movement therapy: Clinical effectiveness is inconclusive and thus is considered experimental and investigational.
- Physical therapy intended to improve or maintain general physical condition or enhance athletic performance is not considered medically necessary.
- Physical therapy that duplicates services provided concurrently as part of an authorized therapy program through another rehabilitative discipline (e.g., occupational therapy).
- Work hardening programs, back school, and vocational rehabilitation because they are training in nature or are not an individualized program specific to a person's needs.

DOCUMENTATION GUIDELINES

Initial Examination/Evaluation/Diagnosis/Prognosis

The physical therapist performs an initial examination and evaluation to establish a physical therapy diagnosis, prognosis, and plan of care prior to intervention.

The physical therapist examination:

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

The physical therapist establishes a plan of care and manages the needs of the patient based on the examination, evaluation, diagnosis, and prognosis; identifies goals and outcomes; describes the proposed intervention, including frequency and duration; includes documentation that is dated and appropriately authenticated by the physical therapist who established the plan of care.

The written plan of care should be sufficient to determine the medical necessity of treatment, including:

- The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis;
- A reasonable estimate of when the goals will be reached;
- Long-term and short-term goals that are specific, quantitative and objective;
- Physical therapy evaluation;
- The frequency and duration of treatment;
- The specific treatment techniques and/or exercises to be used in treatment; and
- Signatures of the patient's physical therapist.

The plan of care should be ongoing (i.e., updated as the patient's condition changes), and treatment should demonstrate reasonable expectation of improvement. Physical therapy services are considered medically necessary only if there is a reasonable expectation that physical therapy will achieve measurable improvement in the patient's condition in a reasonable and predictable period of time.

The plan of care may result in recommendations for additional services including consultation or referral to appropriate disciplines. For example, discharge planning takes into consideration achievement of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral. Collaboration may be with physicians, dentists, nurses, educators, social workers, occupational therapists, speech-language pathologists, audiologists and other personnel involved with the patient management.

The physical therapy intervention:

- Is altered in accordance with changes in response or status;
- Is provided at a level that is consistent with current physical therapy practice;
- Is interdisciplinary when necessary to meet the needs of the patient;
- Uses documentation of the intervention consistent with the Guidelines: Physical Therapy Documentation of Patient/Client Management; and
- Is dated and appropriately authenticated by the physical therapist or, when permissible by law, by the physical therapist assistant.

Reexamination/Reevaluation

The physical therapist reexamines/reevaluates the patient as necessary during an episode of care to evaluate progress or change in patient status and modifies the plan of care accordingly or discontinues physical therapy services.

The physical therapist reexamination/reevaluation:

- Is documented, dated, and appropriately authenticated by the physical therapist who performs it;
- Documents progress made toward the goals of physical therapy. The treatment goals and subsequent documentation of treatment results should specifically demonstrate that physical therapy services are contributing to such improvement. If progression toward identified goals is made, clear documentation with an updated treatment plan is warranted;
- Includes modifications to the plan of care. If no improvement is documented after two weeks of consistent treatment, modifications of the treatment plan should be attempted. If no significant improvement is documented after a total of four weeks of consistent treatment, referral back to the patient's health care practitioner should be considered;
- Utilizes appropriate functional outcome measures (FOMs) to establish goals are being met and improvement is occurring.

Discharge/Discontinuation of Intervention

The physical therapist discharges the patient from physical therapy services when the anticipated goals or expected outcomes for the patient have been achieved. The physical therapist discontinues intervention when the patient is unable to continue to progress toward goals or when the physical therapist determines that the patient will no longer benefit from physical therapy.

The physical therapy discharge documentation:

- Includes the status of the patient at discharge and the goals and outcomes attained;
- Is dated and appropriately authenticated by the physical therapist who performed the discharge;
- Includes, when a patient is discharged prior to attainment of goals and outcomes, the status of the patient and the rationale for discontinuation;
- Includes initial, subsequent, and final FOMs scores;
- Includes proposed self-care recommendations, if applicable; and
- Includes referrals to other health care practitioners/referring physicians, as appropriate.

Standardized Tests and Measures/Functional Outcome Measures (FOMs)

Measuring outcomes is an important component of physical therapists' practice. Outcome measures are important in direct management of individual patient care and for the opportunity they provide the profession in collectively comparing care and determining effectiveness.

The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reexamination/reevaluation, provide information about whether predicted outcomes are being realized. As the patient reaches the termination of physical therapy services and the end of the episode of care, the physical therapist measures the outcomes of the physical therapy services. Standardized outcome measures provide a common language with which to evaluate the success of physical therapy interventions, thereby providing a basis for comparing outcomes related to different intervention approaches. Measuring outcomes of care within the relevant components of function (including body functions and structures), activity, and participation, among patients with the same diagnosis, is the foundation for determining which intervention approaches comprise best clinical practice.

References

(Please refer to ASH policy Selected List of References – Physical and Occupational Therapy – CPG 5 – S.)

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Additional Resources

American Physical Therapy Association Core Documents. Available at www.apta.org/CoreDocuments