



CLINICAL GUIDELINES

Physical Therapy (PT) and Occupational Therapy (OT) Services

V1.0.2022

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Criteria for the Provision of Physical Therapy (PT) and Occupational Therapy (OT) Services (PTOT-1.0)

Definitions (PTOT-1.1)

PTOT.1.1.A

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Skilled Rehabilitative Care

Skilled rehabilitative care is service provided to improve an individual's functional ability and/or structural status (associated with an injury, disability, wound, disease or other condition) that is necessary to return the individual to a reasonable functioning level required to perform their activities of daily living (ADL) and instrumental activities of daily living (IADL). Skilled care shall be of such a level of complexity that the services required can only be safely and effectively performed by a qualified provider. Skilled rehabilitative care generally occurs within a reasonable period of time, is not repetitive or routine, results in a clinically and functionally appropriate response and is guided by evidence-based practice within the professional scope of the provider.¹

Skilled Maintenance Care

Skilled maintenance care is service that is required to create and monitor a specific self-maintenance program for an individual (with help from a caregiver if needed) to prevent or slow deterioration of their ability level and condition. Skilled maintenance care to create, teach and monitor such a program shall be of such a level of complexity that the services provided can only be safely and effectively performed by a qualified provider. Skilled maintenance care visits generally occur infrequently and are only to establish goals and steps of the program with the individual and caregiver. The steps required to follow the program would be carried out independently by the individual and their trained caregivers.¹

Skilled Habilitative Care

Skilled habilitative care is generally defined as services that help an individual to keep, learn, or improve functioning required for daily living. Skilled habilitation shall be of such a level of complexity that the services required can only be safely and effectively performed by a qualified provider. Specific definitions may vary based on state policy, but most states have adopted some version of the National Association of Insurance Commissioners (NAIC) definition.²

Palliative Care

For the purposes of this document, palliative care is typically performed to manage or alleviate symptoms to improve comfort and may not provide corrective or maintenance benefit to the individual's ability level. An individual receiving palliative care, in most instances, demonstrates varying lapses between treatments as the disease progresses. This type of care may not always meet the definitions of skilled care as outlined above; in those instances it may not be medically necessary.³

Preventive Care

Preventive care includes ongoing management of the asymptomatic or stable individual to prevent or avoid disability. Any disability of the individual has already been addressed. The level of skill needed to provide the service is not complex enough to be

deemed as skilled (as defined above). The individual (with help from caregivers as appropriate) can maintain their ability; continued services of this type do not require the skills of a provider.⁴

Non-Skilled Care

Non-skilled care includes any services or procedures that are repetitive or that only serve to reinforce previously learned treatments, skills or repetitious practice for motor learning. It also includes any services or procedures being provided that do not address specific, documented, functional deficits in the individual's essential functions of daily living. Such as care for general wellness, sports or athletic performance, and recreation or hobby activity. Care that was previously skilled may be deemed non-skilled when there has been sufficient time for the individual to respond appropriately to an episode of care and for a home program to be established (with or without a caregiver). Non-skilled services do not involve complex and sophisticated skill or require the judgment of a qualified provider for safety and plan adjustments. The unavailability of a competent person to provide a non-skilled service (caregiver, trainer, coach, etc), regardless of the importance of the service to the individual, does not make that service skilled when a therapist furnishes the service.¹

Essential Functions of Daily Living

Activities of Daily Living (ADLs) are oriented towards taking care of oneself. ADLs are also referred to as basic activities of daily living (BADLs) and personal activities of daily living (PADLs). These activities include bathing, toileting, dressing, eating, mobility, personal hygiene, grooming, sleep, management of health conditions, and sexual activity.⁵

Instrumental Activities of daily Living (IADLs) are activities to support daily life within the home and community that often require more complex interactions such as the care of others, child rearing, communication, driving, household chores, financial management, employment, social interaction, education and essential play (for young children).⁵

Appropriate Response to Skilled Care

An appropriate and significant response to *skilled rehabilitative care* may be demonstrated through:

- An improvement at, or greater than, the established Minimal Clinically Important Difference (MCID) over a reasonable time period for a given standardized functional or performance based outcome measure. This is the smallest statistically meaningful change in a treatment outcome that an individual would identify as important and which would indicate a change in the individual's management.
- Or an improvement greater than an established Minimal Detectable Change (MDC), when there is not an established MCID, over a reasonable time period for a given standardized function or performance based outcome measure. This is a statistical estimate of the smallest amount of change that can be detected by a measure that corresponds to a noticeable change in ability.

- Marked improvement in standard measures appropriate for the individual's specific problem as it relates to their daily life, such as function based performance measures, reliably quantified mobility/ability levels, or quantified integumentary or lymphatic status (healing, surface area, circumference, etc) over a reasonable period of time.
- Marked improvement in multiple measures of participation in ADLs/IADLs and/or appropriate and quantifiable goals and/or symptoms (sensory, radicular, etc).

An appropriate response to *skilled maintenance care* may be demonstrated through:

- The individual and/or caregivers being able to reasonably follow the established program to maintain or slow decline of the present condition or problems.
- A documented need for additional skilled care by a provider to monitor the effectiveness and safety of the established program and make periodic changes to the plan to allow the individual and caregivers to be independent with the program.

An appropriate response to *skilled habilitation care* may be demonstrated through:

- A documented need for continued skilled care based upon appropriate improvement from baseline testing of standardized outcome, performance and/or criterion measures.
- Clear documentation of regular improvement through progress toward appropriate functional goals.

Please reference the Clinical Consideration section [PTOT-2.0: Clinical Considerations](#) below for additional information regarding the use of standardized outcome and performance-based measures to help demonstrate an individual's response to skilled care.

Complexities / Complications

Individuals may present with any variety of situations, conditions or other factors not directly associated with their condition for which they are seeking care but that differentiate them from a "typical" presentation. These complexities may be due (but not limited) to: major medical comorbidities, pathological comorbidities, psychological comorbidities, chronic symptomology, cognitive status, socioeconomic status, multi-system diagnoses, frailty, and medications.

An individual may also experience any variety of new problems or circumstances that directly complicate their current problem for which they are seeking care. These complications may be due (but not limited) to: adverse healing (infections, venous thrombosis, chronic swelling/edema, adhesions or non-closure); neurologic status (radicular symptoms, myelopathy, spasticity, rigidity, or tremors); post-procedural (prolonged procedure, immobilization or activity limitation); or hospitalization.

Condition Severity Grading

An individual's problem or condition can be classified by its severity. Severity is a function of the frequency, duration and intensity to which the problem occurs. Severity

grading helps to provide context to the problem or condition the individual is facing as part of a review for medical need of skilled care. However, it does not guarantee medical need or authorization of care⁶:

- **Mild problem** - the problem is present less than 25% of the time, with a tolerable intensity, and has only rarely occurred in the last thirty days. Generally does not interfere with daily life.
- **Moderate problem** - the problem is present between 25%-50% of the time, with an intensity that sometimes interferes with daily life.
- **Severe problem** - the problem is present between 50%-95% of the time, with an intensity that occurs frequently and partially alters daily life.

Duplicative Therapy Services

Services provided to an individual under two or more different disciplines, or providers, for the same body-part or diagnosis with the same or similar plan of care for treatment are considered duplicate services. This is not the same as interdisciplinary or multi-disciplinary care where an individual may receive care from different disciplines but each with different plans of care, goals and treatments.

Generally Accepted Standards of Practice

For these purposes, generally accepted standards of practice are widely accepted clinical concepts and practices based on published, credible, high-level, scientific, evidence-based clinical practice guidelines. In the absence of such guidelines for a specific area of practice, a collection of high-level established peer-reviewed literature may also be generally recognized by the relevant healthcare community.⁷ [PTOT-2.0: Clinical Considerations](#) section of this publication provides additional context in reference to usual and reasonable care for common specialty areas of skilled care.

Individual

For the entirety of this document, the term “individual” refers to the person for whom services are requested (i.e. patient, client) AND/OR any non-clinical caregivers or caretakers (including caregivers, restorative staff, parents, guardians, family, friends, etc) that are assisting them.

Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care (PTOT-1.2)

PTOT.1.2.A

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Initiation of Skilled Rehabilitation/Habilitation Care

Due to the complex nature of an individual's diagnosis, complexities and complications, and limitations inherent with using standardized measures of change, all pertinent and applicable clinical information documenting an individual's problem and its severity will be considered as part of the review process.

The initiation of an episode of physical and occupational therapy services for skilled habilitation/rehabilitation will be considered medically necessary when current information is submitted to demonstrate that ALL of the following criteria have been met. Failure to meet ANY of these criteria would indicate skilled care is not necessary:

1. The skills of a qualified provider are required to address a documented significant specific functional deficit in essential daily tasks (ADL/IADLs) and/or a specific integumentary or lymphatic condition that require care of such complexity and sophistication that only a qualified provider can address them safely. Merely providing services by a qualified provider do not, alone, make them skilled or necessary. The services must meet the required level of complexity for skilled care as defined in [PTOT-1.1: Definitions](#).
 - a) The functional deficit, integumentary or lymphatic condition or milestone deficiency is quantified in a standardized and valid manner (additional detail about common standard measures are provided in [PTOT-2.0: Clinical Considerations](#)) and is new or that has changed or declined from their previous level of functioning requiring skilled care.
 - b) The skilled care being requested is NOT specifically related to continued participation in elective or recreational activities such as sports, athletics, endurance, wellness, weight reduction or hobbies in the absence of deficits with essential function of daily living.
2. The recommended plan of care is reasonable and generally accepted as within the standard of practice of the provider to be effective for the individual's documented problems (See Generally Accepted Standards of Practice in [PTOT-1.1: Definitions](#)). The care is not primarily passive or routine.
3. There is an expectation that the individual will respond appropriately and favorably to the plan of care in a reasonable and generally predictable period of time

resulting in discharge to an independent program (with or without help from caregivers)

4. There is an expectation that the individual will be actively compliant with all aspects of the recommended plan of care, including regular participation in their home program.

Initiation of Skilled Maintenance Care

When covered by the health plan, the initiation of an episode of physical and occupational therapy skilled services will be considered medically necessary to create a maintenance program when current information is submitted that demonstrates ALL of the following criteria have been met. Failure to meet ANY of this criteria would indicate skilled maintenance care is not necessary:

1. The skills of a qualified provider are required to establish or design a maintenance program to be carried out by the individual and their caregivers appropriate to their capacity and tolerance.
 - a) The individual's current functional status is no longer rapidly changing, but should be maintained to promote safety, current ability level or slow deterioration, but there has not yet been a reasonable opportunity to establish a program.
 - b) A customized program to maintain the individual's ability requires such complexity and sophistication that it can only be established by a qualified provider.
2. The recommended plan to establish the maintenance program is reasonable and generally accepted as within the standard of practice specific to individual's condition (See Generally Accepted Standards of Practice in [PTOT-1.1: Definitions](#)).
3. There is an expectation that the individual and or caregivers will follow through on their own with the established program and goals are appropriate in regards to maintaining a program versus goals for rehabilitation/habilitation.

Determination of dosage of skilled care

The frequency, duration and quantity of skilled care services is based on the severity of the objective clinical findings, complexities and complications, history and chronicity of the individual's conditions, anticipated or actual response to services, and an individual's level of independence. These findings will be considered in relation to what would be reasonable and generally acceptable practice to determine a dosage of care that allows for appropriate skilled services but also for appropriate time between clinical sessions for the individual to practice their program. Dosage of skilled care should be specific to an individual's situation and should be adjusted appropriately throughout an episode of care.

Continuation of Skilled Care

Consideration of the need for continued skilled care (habilitation/rehabilitation/maintenance) beyond the initial request for care of an episode involves determining that an individual is responding appropriately to the type of care or program being provided, yet still requires additional skill from a provider.

It is generally expected that as an individual responds appropriately to care over a reasonable timeframe their need for continued care should decrease and their ability to self-manage (or maintain) should increase. Similarly, it is generally expected that for individuals with conditions that result in a functional plateau or even progressive decline, their need for continued care should decrease as they learn to self-manage and modify daily tasks. Initial services should have allowed time for the individual and caregivers to be educated on a home program and self-care strategies. This decrease in need should result in modification to the dosage of care to allow time between visits for the individual to progress with their home program resulting in a discharge from skilled care as the individual approaches independence in ADLs/IADLs or in their appropriate maintenance program. Failure to meet ANY of the criteria for continued care would indicate skilled care is no longer necessary, or not necessary as requested.

In addition to the criteria for initiation of skilled care laid out above, requests for continuation of treatment (those beyond the initial request) must also include current information that demonstrates all of the following are MET:

1. An individual is responding appropriately to their plan of care or established program (See Appropriate Response to Skilled Care in [PTOT-1.1: Definitions](#).)
-OR-
There is a significant decline in the condition that has not previously been addressed in this episode of care (flare up, etc.) that has resulted in a statistically meaningful deficit in ADLs/IADLs and that requires a change to the plan of care of such complexity and sophistication that only a qualified provider can address it, such as:
 - a) There has been an exacerbation of symptoms despite adherence to care plan, but the individual was otherwise responding appropriately.
 - b) Progression of symptoms has occurred despite adherence to a care plan and skilled care is needed to modify or alter the care plan to address changes.
 - c) There has been a significant complication that was not previously present (refer to Complexities/Complications in [PTOT-1.1: Definitions](#).)
2. The services provided continue to be at an appropriate skill level and are progressing
 - a) The services are not routine or repetitive and continue to be of such complexity and sophistication that only a qualified provider can provide them safely. The services are NOT for pain mediation alone (following initial care to establish a maintenance program) and are NOT to maintain participation in elective activities only.

- b) The individual's maintenance program is no longer effective and they now require specific changes, modification or training of such complexity that they can only be addressed by a qualified provider. The general lack of a competent caregiver, the unwillingness or inability of the individual to arrange for a caregiver, or the unwillingness of the individual and/or a caregiver to carry out a care program does not apply.
- 3. The individual continues to be compliant with the recommended plan of care or program and is consistently making an effort to participate in all aspects of their care. This would include adherence to their home-program, attendance to and being active in scheduled care sessions, utilizing appropriate caregivers and assistive devices, and modifying activities to avoid continued harm or exacerbations.

Duplication of Services

An individual's specific problem can improve with skilled care from one provider and one treatment plan. Duplicative care (See Duplicative Therapy Services in [PTOT-1.1: Definitions](#).) is not considered medically necessary.

Discontinuation of Skilled Care

Requests for physical and occupational therapy services that do not meet the criteria for initiation or continuation of skilled care would be considered not medically necessary.

Rules, Coverage, Benefits, and Mandates (PTOT-1.3)

PTOT.1.1.A

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Specific rules pertinent to submitting a request for skilled care will vary by health plan. Rules, policies, and member coverage benefits pertaining to each health plan may take precedence over eviCore's medical necessity criteria. Applicable federal or state health mandates may also take precedence over eviCore's medical necessity criteria [i.e. Early and Periodic Screening Diagnostic and Treatment Mandate (EPSDT), State Autism Mandates]. Requests for skilled care where these policies and mandates apply will be processed according to that policy and may not require a review for medical necessity according to eviCore's medical necessity guidelines.

For Medicare programs, the coverage policies of Centers for Medicare and Medicaid Services (CMS) take precedence over eviCore's medical necessity criteria. These may vary based on the Medicare Administrative Contractor (MAC) of the jurisdiction where the individual has a health policy. In the absence of an applicable Local Coverage Determination, Local Coverage Article or National Coverage Determination, eviCore policies will apply for the determination of medical necessity for skilled care services. This also applies to skilled services being billed as "incident to" by physician providers.⁸

eviCore takes into consideration any applicable benefits, rules, policies and mandates when processing requests for skilled care. The final determination of reimbursement for PT and OT Services is the decision of the health plan and is based on the individual's policy rules, benefit entitlement structure, or any mandates that apply. Providers and individuals should reference health plan policies and rules, federal or state health mandates, and MAC policy for any concerns about covered and non-covered skilled care services.

Clinical Considerations (PTOT-2.0)

Clinical Considerations (PTOT-2.0)

PTOT.2.0.A**v1.0.2022**

To demonstrate a need for skilled care or planning, the previously established criteria in [PTOT-1.2: Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care](#) must be met. However, there are many variations in conditions, diagnoses and limitations as to why an individual could seek skilled care. There are different areas of discipline, concentration or specialty within skilled care that may cater to these variations. Effective treatment options vary from case to case. There are a variety of ways an individual can improve or respond to their plan of care. The following section and its subsections serve to provide supplementary context to assist in understanding what constitutes reasonable care and an appropriate response to care within common clinical areas while keeping in mind this variation and evidence-based recommendations.

Individuals will present with conditions along spectrums of severity and chronicity. As an individual responds appropriately to skilled care the severity of their problem or need for care is expected to improve. Mild problems may require little to no skilled care. More severe problems may need more regular care. How long a condition has been present, ranging from acute, sub-acute, to chronic, may also have some bearing on the amount of care required. Severity and chronicity are part of the clinical context that is considered on an individual case basis.

The effect that complexities and complications (See Complexities/Complications in [PTOT-1.1: Definitions](#)) may have on the individual's ability to respond appropriately to the skilled care provided will be considered on a case-by-case basis. It is the responsibility of the provider to submit information regarding any complexities or complications to be considered and how these are impacting the individual's functional levels and their response to care. The mere presence of a complexity or complication alone does not meet the inclusion criteria established in [PTOT-1.2: Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care](#).

Determining an individual has a limitation that requires skilled care or planning is essential to meeting the criteria established in [PTOT-1.2: Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care](#). Furthermore, having an appropriate and significant response to skilled care is required to show a continued need of care. Standardized and valid functional outcomes, performance based measures, and condition specific measures are recommended to be used to quantify levels of deficit and appropriate response to care (See Appropriate Response to Skilled Care in [PTOT-1.1: Definitions](#)) being provided regardless of condition or diagnosis. Standardized measures should be used throughout an episode of care to track progress. Measures used should reflect the condition and goals of the individual.⁹⁻¹¹ There are many valid and standard measures available for a variety of functional deficits, conditions, diagnoses, ability levels, risk levels and severity levels. There are many comprehensive online resources to help educate providers on appropriate tests. It is the skilled provider's responsibility to choose appropriate measures specific to the needs and goals of the individual under their care.¹²⁻¹⁴ It is the provider's responsibility

to know how to appropriately administer, score, track and document the standard measures they have chosen. In rare instances where standard measures are not appropriate, it is the provider's responsibility to document these reasons and to provide alternative quantifiable measures of progress. (For the convenience of the provider when going to submit clinical information for review, eviCore does have clinical worksheets available with some common standard measures at www.evicore.com. Not all possible measures are listed.)

It is acknowledged that standard measures are not free from some levels of subjectivity, bias and error. Clinical information beyond standard scores can help inform on the individual's complete situation and problems. All efforts are made during the review process to consider submitted scores within the entire clinical context of the individual and their situation. All pertinent and applicable clinical information documenting an individual's progress is considered during the review process.

eviCore takes into account current scientific evidence-based recommendations when evaluating a request for an appropriate need for skilled care. Generally accepted standards of practice (See Generally Accepted Standards of Practice in [PTOT-1.1: Definitions](#).) are evidence based and help define what is considered to be reasonable care. Episodes of skilled care and the treatments provided can vary for similar diagnoses and/or patient groups yet still result in an appropriate clinical response. Therefore, the need for skilled care is evaluated based more so on the individual's presentation, response to the plan of care, and their ability for self-care than on specific treatments or techniques. Even though clinical trial research may show one particular treatment or technique is effective for a specific problem within a research group, that does not automatically mean an episode of skilled care is required or should be ongoing. Care that deviates significantly from what is regarded as generally accepted can fail to meet the criteria to establish medical need.

Integumentary Considerations (PTOT-2.1)

PTOT.2.1.A

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Wounds, burns, and skin conditions are typically characterized by the disruption of integumentary integrity and can be of an acute or chronic nature. Chronic non-healing wounds, burns, and skin conditions fail to progress through a timely sequence of repair or proceed through the wound healing process without restoring anatomic and functional results. Wounds are generally defined as being chronic after 1 to 3 months of elusive healing.¹⁵ The etiology of a skin lesion frequently assists in determining the treatment protocol. The Wound Healing Society classifies wounds according to four major etiologies: pressure ulcers, venous ulcers, arterial insufficiency ulcers and diabetic foot ulcers.¹⁶ The five etiologies of burns include: thermal, chemical, electrical, radiological, and cold exposure.¹⁷ Skin conditions and atypical lesions can have multiple etiologies, including: skin tumors, hypersensitivity syndromes/vasculitis, bullous diseases, connective tissue/skin diseases, cutaneous manifestations of internal diseases, factitious wounds, and animal bites.

Consideration of the need for skilled care for an individual with wounds, burns, or skin disorders necessitates determining the degree of tissue destruction present. Standardized tools that measure the severity of tissue loss are recommended to be used to demonstrate levels of abnormality [i.e. NPUAP Classification for Pressure Injury Staging, ABA Thermal Injury Classification]. Characteristics of the compromised tissue and wound bed must also be evaluated in order to appropriately manage skin disorders. Standardized, valid measures of lesion size, depth, tissue type, exudate, undermining, and tunneling are recommended to be used to demonstrate levels of abnormality when determining the need for skilled medical intervention. Baseline measures of tissue and wound bed characteristics should be assessed at the initiation of an episode of care. It is also recommended that these measurements be used weekly throughout an episode of care to track progress.¹⁸

The tracking of tissue healing or tissue deterioration over a given period of time will help determine when continued skilled care is recommended. There valid and standard methods of tracking skin lesions and conditions. Standard measures should be used throughout an episode of care (See [PTOT-2.0: Clinical Considerations](#)). Only when there is documented evidence of clear benefit from the services provided, should services be continued. A 50% reduction of diabetic foot ulcer size in four weeks is a strong predictor of complete healing in 12 weeks.¹⁹ In addition, a reduction in size of venous leg ulcers that is less than 40% at four weeks indicates that complete wound closure at 24 weeks is unlikely.²⁰ Superficial burns are expected to completely heal in 3-5 days, superficial partial thickness burns typically heal within 2-3 weeks, and deep partial thickness burns heal within 3-9 weeks. Full thickness burns will often require extensive debridement and/or skin grafting.²¹ Each individual will respond differently to these interventions. Wounds and skin conditions will not always heal in a predictable manner, despite the utilization of skilled interventions that have been scientifically

validated to promote wound healing. In general, the failure to document any progress in wound healing over an ensuing 30 days indicates the lesion is failing to heal.

Consideration of the need for skilled care for an individual with wounds, burns, or skin disorders also necessitates determining any associated functional deficits. A lesion's impact on an individual's ability to perform ADLs/IADLs may possibly include restricting motion of associated joints and tissues or restricting functional mobility due to the need for off-loading or immobilizing affected limbs. Use of other common standard measures for daily function should also be used when limitations in ADLs/IADL are present.

Individuals with wounds, burns, and skin conditions can present with various complexities and complications during an episode of care which could potentially compromise the normal tissue healing process. Common complications are infection and biofilm. Individuals may have autoimmune, metabolic or vascular disorder that impair healing. Infections, necrotic tissue, and foreign bodies can directly compromise the normal tissue healing process. Compromised tissue integrity and tissue healing may generate the dysfunction of other body systems. Vascular incompetence, development of musculoskeletal contractures, or further tissue destruction may occur and require the need for surgical intervention.^{22,23} Severe burns may have received skin grafting or other surgical intervention. These complexities are not meant to be comprehensive of all instances requiring skilled care. The effect that complexities and complications may have on an individual's skin condition or wound to respond appropriately to the skilled care provided will be considered on a case-by-case basis (see Complexities/Complications in [PTOT-1.1: Definitions](#).)

Current peer-reviewed recommendations for skilled care of wounds/lesions indicate skilled care when there is clear refractory to healing, failure of wounds/lesions to progress through normal healing in a timely manner, or there are complicated healing cycles. Current best evidence suggests that skilled care for skin lesions can restore skin integrity and function. Skilled wound management should encompass effective therapeutic interventions and the eventual transition to self-management program. There is a wide range of dressings and treatments for wounds and burns.²⁴ Care should be specific to the needs of the individual. Current recommendations for skilled intervention consider lesion etiology, severity of tissue destruction, tissue/wound bed characteristics, and functional impairment. Less severe tissue destruction may only require self-care, including wound cleansing and dressing changes, with occasional monitoring. If the tissue destruction is more significant, an episode of skilled care may be supported.

Validated research based therapeutic interventions include the use of biophysical agents, including: sharp debridement, electrical stimulation, phototherapy (UVA, UVB, UVC), ultrasound, cleansing, pulsed lavage with suction, and negative pressure wound therapy. Application of Unna boots, contact casting, splints, short stretch bandaging, dressings and multilayer bandaging have been well researched and validated for the treatment of wounds, burns, and skin conditions. Wound cleansing and dressing changes as a standalone treatment option is not strongly recommended. Home programs for self-management may include tissue hygiene maintenance, compression treatment, contracture management and off-loading orthotics/devices once the wound is stabilized. Patient education regarding long-term maintenance and self-management

should include patient specific strategies, including tissue hygiene maintenance, compression treatment, and contracture management and off-loading orthotics/devices once the wound is stabilized.²⁵⁻³⁰

Lymphatic Considerations (PTOT-2.2)

PTOT.2.2.A

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Lymphedema is typically characterized by an abnormal build-up (volume) of lymphatic fluid within the tissues beneath the skin that causes localized edema accumulation, which may lead to further integumentary sequelae. Accumulation of edema can impact an individual's ability with ADLs/IADLs through restricting mobility of associated joints and tissues and increasing the overall weight of affected areas. The accumulation may impact the health and function of other body systems in the affected area such as circulation, nerve, skin, and internal organs. It is the result of a disruption to the normal flow of an individual's lymphatic system. Lymphedema is a chronic condition with varying stages and care needs over time.

Consideration of the need for skilled care of an individual with lymphedema necessitates determining the stage of progression (i.e. Stage 0-III from International Society of Lymphology) and any associated ADL/IADL deficits.³¹ Baseline measures of volume, function, and ability should be assessed at the initiation of, and throughout, an episode of care (See [PTOT-2.0: Clinical Considerations](#)).

Tracking of volume overtime will help inform when skilled care is recommended to commence. Current peer-reviewed recommendations suggest commencing skilled care when limb volume is demonstrating regular asymmetrical swelling of approximately >5% in the UE or >10% in the LE.³² One isolated measurement of excessive volume is generally not sufficient to indicate a need for regular skilled care. It is understood that lymphedema will not always remain confined to easily measurable body areas or to one limb or region only. The individual's medical history and symptoms also play a role in diagnosis and treatment. Attempts to quantify and track the edema should still be made. Past history should also be used to inform on the chronicity of the swelling, including previous treatment and self-management.³³

An individual may be seeking skilled care for lymphedema that is the result of surgeries or procedures to address cancer or other pathologies. Techniques and approaches for these surgeries and procedures will vary greatly, and each individual will respond differently. Their need for skilled care will be assessed based on all clinical information presented that meets the indications for care in consideration of associated complexities and complications, including specific post-surgical limitations and protocols.

Published peer-reviewed clinical practice guidelines and systematic reviews for lymphedema support that skilled care can reduce swelling and transition individuals to a self-maintenance program to be used over time.³⁴⁻³⁶ Current recommendations correlate with what stage of lymphedema an individual is experiencing. The less severe stages may only require self-care, occasional monitoring, elevation and/or compressive garments. As the edema progresses in severity, an episode of skilled care for complete decongestive therapy (CDT) is recommended. Treatment generally consists of two phases: Decongestive and maintenance. CDT should encompass active strategies, education on skin hygiene, adherence to daily self-care home program, and appropriate manual lymphatic drainage. As the edema stabilizes, care should transition

to the maintenance phase. This phase should include education to transition the individual to self-management via appropriate compression options (garments, bandages, pumps), self-massage, positioning, skin care, caregiver assistance, and activity levels. Manual therapy as a standalone treatment option is not recommended. The use of passive modalities is inconsistently supported and should not generally make up the bulk of care provided.

Musculoskeletal Considerations (PTOT-2.3)

PTOT.2.3.A

v1.0.2022

Musculoskeletal (MSK) conditions are typically characterized by limitations in mobility, strength, coordination, and balance, leading to functional deficits in activities of daily living. Acute or chronic pain may also be present. General orthopedic conditions affect muscles, bones, joints and related tissues such as tendons, ligaments, and nerves. MSK conditions can also present in combination with neurological signs, such as radicular symptoms, nerve compression, or myelopathy. Individuals with MSK conditions can present with varied complexities and complications during an episode of care (See Complexities/Complications in [PTOT-1.1: Definitions](#).) which will be considered along with all clinical information. Conditions identified as chronic pain syndromes often present with similar limitations and may receive similar care options as other MSK conditions. However, it is acknowledged that pain syndromes can be multifactorial and there may be clinical considerations beyond just MSK in some situations. As with all cases, requests for skilled care of chronic pain syndromes will be considered case-by-case with all clinical information provided.

Consideration of the need for the skilled care of an MSK condition necessitates determining that an individual presents with a specific problem that significantly limits their ability with ADLs/IADLs. Baseline function should be assessed at the initiation of an episode of care and regularly throughout an episode. Standard function and performance based outcomes are recommended to be used for baseline and continued tracking of an individual's ability (See [PTOT-2.0: Clinical Considerations](#).). It is expected that an individual will respond appropriately to skilled care in an appropriate and predictable amount of time.

An individual may be seeking skilled care for an MSK problem in relation to an injury where a procedure or surgery was performed, or will soon be performed, to help correct a structural issue. Often referred to as an orthopedic procedure or surgery. Surgical approaches and technique will vary. Each individual will respond to their procedure differently. Their need for skilled care will be assessed based on all clinical information presented that meet the indications for care (See [PTOT-1.2: Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care](#).) in consideration of associated complexities and complications. This includes any consideration of specific post-surgical protocols.

There is a significant body of published high-level guidelines and systematic reviews for many common MSK conditions.³⁷⁻⁶¹ Recommendations from these sources suggest care for an individual with an MSK problem should encompass physically active strategies, functional training, patient and caregiver education that address specific disabilities and goals, as well as use of valid outcome- and performance- based measures. Strong recommendations have been made that services should be customized to the individual. It is recommended that individuals be provided with progressive home and self-care programs so they can regularly work on the repetitive

aspects of their care plan on their own. Care should empower an individual and their caregiver to become independent once a home program is established, especially in the case of chronic pain conditions. There is some moderate-level evidence to support the use of combining some short term manual therapies along with active solutions as part of a comprehensive program, but manual therapies should not be a majority of the care provided. Evidence for the use of passive treatments and techniques ranges from not recommended to weak evidence for limited use. Skilled care should primarily be active in nature with transition to a home program as soon as possible. Passive treatments should generally be avoided; use should be limited to acute stages in an effort to allow better tolerance to active care.

Neurological Considerations (PTOT-2.4)

PTOT.2.4.A

v1.0.2022

Neurological conditions are typically characterized by limitations with ADLs/IADLs such as with mobility, strength, coordination, and balance, due to nervous system dysfunction. Individuals with neurologic dysfunction may also demonstrate limitations in cognition, memory, sensory function, vision, social function, and communication. Neurologic conditions may be acquired due to congenital malformation, trauma/insult, or as a result of disease processes that affects the nervous system. The extent of nervous system dysfunction can vary greatly and may change over time. Neurological dysfunction may range from acute, sub-acute, or chronic states expressed as varying levels of disability. Individuals with neurologic conditions or disease can present with varied complexities and complications during an episode of care (See Complexities/Complications in [PTOT-1.1: Definitions](#)). One individual with a neurologic condition may improve ADLs/IADLs ability quickly over time, where another may remain at a functional plateau or even decline (especially in the case of progressive disease) in their ability.

Consideration of the need for skilled care of a neurologic condition necessitates determining that an individual presents with a specific problem that significantly limits their ability with ADLs/IADLs that has not yet been addressed through skilled care. Baseline measures of function, sensation, and cognition should be assessed at the initiation of an episode of care and tracked throughout the episode of care through the use of standard and valid measures (See [PTOT-2.0: Clinical Considerations](#)). It is expected that an individual will respond appropriately to skilled care in a predicted amount of time. Whereas many neurological conditions and diseases may result in permanently or progressively worse neurological dysfunction as compared to previous baselines, it often may not be appropriate to expect a full return of abilities. How much an individual is expected to improve, plateau, or decline must also be part of a consideration for the need for skilled care. Neurological conditions may reduce the ability of a provider to get reliable assessment scores. These situations should be clearly documented. All efforts are made during the review process to consider submitted scores/measures within the clinical situation of the individual.

Individuals with neurological conditions may be classified into severity groupings utilizing any variety of established scales or criteria, such as, but not limited to, the American Spinal Injury Association Classification Scale, Modified Ashworth Scale, Glasgow Coma Scale, Hoehn and Yahr Stages, Unified Parkinson's Disease Rating Scale, etc. An individual may also be categorized within varied stages of a primary disease, such as one of four disease courses of multiple sclerosis or one of five major types of cerebral palsy. These groupings and classifications can be helpful in identifying typical presentation, severity, progression, and prognosis. They may also assist in determining treatment approaches. This clinical information may provide insight during a review of a request for skilled care. However, authorization of care will

be based on the current functional need of the individual and not on a classification alone.

There is a significant body of published high-level guidelines and systematic reviews for common neurological conditions and disease.⁶²⁻⁷³ Their recommendations indicate that skilled care for neurological conditions should encompass customized techniques and training that are task oriented, progressive, and at an appropriate intensity to drive an appropriate functional response. The skilled care should focus on active motor strategies and patient/caregiver education that addresses specific disabilities and goals. Strong recommendations have been made that caregivers should be involved during all stages of an episode of care. There is good evidence to support the benefit of targeted exercise and training on mobility problems. There has been increased emphasis in recent years on the importance of greater intensity of activity an individual should be advised to perform as part of their program. If the required exercise is not challenging or is routine, it may not drive positive change. Evidence for the use of passive treatments and techniques to improve function ranges from “not recommended” to “insufficient evidence” to “weak evidence” for limited use. Skilled care should primarily be active in nature with transition to a home program as soon as possible, as a way of empowering the individual and their caregiver. Evidence to support the regular use of body-weight support training, robotic/exoskeleton support training, and vibration plates is currently inconclusive. Repetition is an important part of a skilled care program; there is evidence that individuals can learn a home program with their caregivers and repeat their program between in-clinic sessions. It is also recommended that individuals and their caregivers be educated on the reality of their neurological condition and be given realistic goals and expectations.

Sensory dysfunction as part of any neurologic condition can negatively affect an individual's ability with ADLs/IADLs. Current research mostly focuses on the motor aspects of recovery. However, there is evidence to suggest positive effects from sensory training for those with acquired neurological dysfunction and that it can enhance task-oriented functional training. Recommendations appear to favor passive sensory training over active.^{72,73}

Current best evidence recommends that individuals with progressive disease may need access to episodes of skilled care across their lifespan as their mobility and sensory needs change. For those in early or less severe stages of their disease, needs may be addressed with education, self-care programs, or a very limited course of care. As their disease progresses, their needs may change on an episodic basis requiring further assessment of their mobility, ADL ability, and safety risks. It is recommended that care be used to optimize an individual's functional status given any new progression of disease. Encouraging self-management with realistic expectations is recommended.^{63,65-67,70,71}

Individuals with congenital neurological dysfunctions can benefit from skilled care. Habilitative training can assist in reaching developmental milestones (for pediatric considerations please refer to [PTOT-2.5: Pediatric Neurodevelopmental Considerations](#)). As these individuals grow and mature, they may encounter new motor and sensory limitations that had not previously been addressed. Evidence recommends that care be specific to the individual and focus on active, task-specific,

strategies. Therapy should be moderate to high intensity requiring sufficient effort from the individual.⁶⁸

Pediatric Neurodevelopmental Considerations (PTOT-2.5)

PTOT.2.5.A**v1.0.2022**

Neurodevelopmental conditions disrupt typical growth and development, usually characterized by abnormal motor and sensory skills presenting as limitations in mobility, strength, coordination, balance, mental processing, sensory processing, behavior and essential functions of daily living (See Essential Functions of Daily Living in [PTOT-1.1: Definitions](#)). These restrictions lead to functional deficits in essential life roles. Progression of the condition may occur as the child ages. Gross, fine, and/or perceptual skills can be limited with varying severity.

Severity of the developmental disability is determined through standardized testing and lack of or delay in reaching developmental milestones.^{74, 75} The diagnosis and age of the child are also taken into consideration when determining severity. Severity of the child's disability may be expressed through specific levels or stages of disease/condition [i.e. Gross Motor Function Classification System, Duchenne muscular dystrophy stages 0-5, and Congenital Muscular Torticollis grade 1-8]. It is the responsibility of the provider to know how to appropriately choose and administer standardized tests to determine the severity of a child's disability. There may be situations where standardized assessments are not available or appropriate. These situations should be documented clearly and alternative quantitative assessments of the child's ability provided.

Individuals with a pediatric disability/condition can present with varied complexities and complications (See Complexities/Complications in [PTOT-1.1: Definitions](#)). These complexities and complications may change as the child grows and matures. Periods of growth and development can present new challenges in the child's motor skills, ability levels and sensory processing.⁷⁴⁻⁷⁶ Complexities and complications may arise due to other medical procedures, surgeries or medication changes.⁷⁷ Consideration of the need for the skilled care of a pediatric condition necessitates determining that an individual presents with a new specific problem that significantly limits their ability to achieve developmental milestones or their ability to perform essential functions of daily living.

Baseline standardized testing of milestone attainment and deficits in essential tasks should be assessed at the initiation of an episode of care.⁷⁴⁻⁷⁶ It is expected that an individual will respond appropriately to skilled care in a generally predicted amount of time. Appropriate measures should be used at regular intervals to track the response to care being provided (See [PTOT-2.0: Clinical Considerations](#)). In special situations where these measures are not able to be performed, clinical observation and objective information may be provided to demonstrate the level of functional deficit.

Current peer reviewed guidelines recommend skilled care for individuals presenting with pediatric neurodevelopmental conditions should be task oriented.⁷⁴⁻⁸⁰ Strong evidence recommends goal directed approaches involving the whole task [i.e., if the goal was handwriting, the whole task of handwriting should be addressed, not just

focusing on finger dexterity].^{78, 80} Goals should be developed collaboratively with the child and parent/caregiver as well as the clinician at increments appropriate for the child's level of ability and progress. These goals should be practiced in the home and community environments and updated appropriately. Skilled care should be enjoyable and motivating to the child.^{74-76,78-80} In addition, there are strong recommendations for parents/caregivers to be taught appropriate play and developmental activity strategies through coaching and education.^{75, 80} Skills should be practiced with parents/caregivers in the natural environment and incorporated into structured home programs to support the child and better understand the child's behaviors. Parent participation is essential. Treatment options that are more passive, such as therapist-controlled handling (i.e. passive stretching and range of motion) and sensory integration alone, are not well supported.⁷⁹ The child should be an active participant in the activity. For children and young people who are considered to have a severe motor impairment, evidence is low in regards to the benefit from interventions to improve function. These individuals contribute to everyday tasks through small actions and changing environmental factors with the use of adaptive equipment to support function and inclusion.⁷⁸ Adaptive equipment and assistive technology may be beneficial.

Pelvic Considerations (PTOT-2.6)

PTOT.2.6.A

v1.0.2022

Pelvic dysfunction is typically characterized by pain, limitations in mobility, strength, function, sensation, and coordination of associated pelvic anatomy. Pelvic conditions can be a result of pregnancy, trauma, various surgeries, structural deficiencies, neurological dysfunction, or disease processes. Functional deficits in specific activities of daily life such as bowel and bladder continence, pelvic organ stability, and sexual function may present in varying degrees. Pelvic conditions may present in combination with other musculoskeletal and neurological conditions. They may also present with various complexities and complications which may affect their rehabilitation prognosis. They may range from acute, sub-acute, or chronic states expressed as varying levels of pain and disability.

Consideration of the need for the skilled care necessitates determining that an individual presents with a specific problem that significantly limits their ability to perform daily functions related to the pelvic region and organs. Standardized, valid, functional outcome- and performance- based measures are recommended to be used to demonstrate levels of dysfunction and measure appropriate response to care throughout an episode (See [PTOT-2.0: Clinical Considerations](#)).^{81, 82} Due to the intimate nature of functions related to the pelvic region, some dysfunctions may also be monitored through performance based means such as bladder diaries to assess voiding/incontinence patterns, or tracking frequency of applicable incidents of a specified dysfunction. Measuring performance over time can be a useful tool in tracking response to care and progress. Where possible, it is still recommended that valid standard measures be used alongside performance measures.

Gynecological, urological, gastrointestinal, or colorectal surgical interventions may be used to help correct a pelvic dysfunction; or the pelvic dysfunction may be an adverse result of a surgery to correct other abdominal/pelvic conditions. Surgical approaches and technique will vary. Each individual will respond to their procedure differently. The need for skilled care following any surgery will be assessed based on all clinical information presented that meets the indications for care (See [PTOT-1.2: Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care](#)) in consideration of associated complexities and complications. This includes any consideration of specific post-surgical protocols.

Pregnancy and any subsequent postpartum recovery, are periods of rapid, significant, and often traumatic changes to the pelvic anatomy. These relatively rapid changes may result in pelvic discomfort, pain, altered posture, and instability. An individual may seek skilled care to help address pelvic problems associated with pregnancy and the postpartum period. Uncomplicated pregnancy and delivery, although potentially traumatic, is often self-limiting, and recovery generally occurs gradually over time, without skilled care, as the individual returns to their normal lifestyle. However, complications during pregnancy, delivery, and postpartum do occur. These complications, and any associated interventions, can vary significantly from one individual to another.⁸³ An individual's need for skilled care related to pregnancy and

postpartum recovery will be assessed case-by-case based on their current functional deficits and all pertinent clinical information that meet the indications for care (See [PTOT-1.2: Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care](#)).

There are recent published guidelines and reviews that provide recommendations of reasonable skilled care for pelvic dysfunctions.⁸²⁻⁸⁶ Strong recommendations have been made that skilled services should be customized to the individual. Physically active strategies such as pelvic floor muscle training, bladder diaries and increasing physical activity should be considered as first line skilled care options. Pelvic floor muscle training programs have been recommended as first line care options for most pelvic dysfunctions. Providers should be familiar with current exercise recommendations and contraindications for individuals during the antepartum period. It is recommended that supervision of a care program should incorporate encouragement to complete a regular home program, and tailoring of the exercise program to the individual's needs. Home programs should focus on incorporating active treatments into daily life. Skilled care and any education should empower the individual and any caregiver to follow their home program regularly to allow for a quick transition to discharge. Use of manual therapies should not be a majority of care provided, but may be beneficial as a short term adjunct to facilitate active strategies. Evidence for the general use of passive treatment techniques such as biofeedback, and electrical stimulation for pelvic dysfunctions is inconclusive. Stimulation may be recommended for individuals that cannot actively contract their pelvic floor musculature. Passive treatments should generally be avoided; any use limited to acute stages in an effort to initiate or allow better tolerance to active care.

Swallowing and Feeding Considerations (PTOT-2.7)

PTOT.2.7.A

v1.0.2022

Swallowing and feeding disorders are typically characterized by impaired oral intake that is not age appropriate or safe. Swallowing and feeding disorders can also present in combination with developmental and neurological conditions, prematurity and low birth weight, genetic syndromes, trauma, cancer, oral structural abnormalities, etc. The severity of a swallowing or feeding disorder is related to nutritional/ growth and safety concerns and the need for supplemental/ enteral nutrition.

Consideration of the need for skilled care for a swallowing and feeding disorder necessitates determining that an individual presents with a specific problem that significantly limits nutritional intake and/or is a safety concern. Baseline feeding skills should be assessed at the initiation of an episode of care. Standardized, valid, functional and performance based measures are recommended to be used throughout an episode of care to demonstrate levels of feeding deficit and appropriate response to care being provided (See [PTOT-2.0: Clinical Considerations](#)).^{74,75} Additional information specific to swallowing and feeding concerns will be considered along with standard scores. This may include food/drink types, textures, quantities; oral motor skills; growth/nutrition concerns of medical professionals; functional imaging assessments (such as fluoroscopic swallowing studies); supplemental nutrition; caregiver participation; and any additional complexities of the individual's situation. It is expected that an individual will respond appropriately to skilled care in a predicted amount of time

There is an established body of published high-level guidelines and reviews that provide recommendations on reasonable care for swallowing and feeding disorders. These recommendations suggest that skilled care for swallowing and feeding should focus on treatment strategies that are task-specific. Skilled care should primarily be active in nature with transition to a home program as soon as possible.^{75,75,79} Repetition is an important part of a skilled care program. Individuals and caregivers can learn a home program and repeat their program between direct skilled care sessions. As the individual's needs change, skilled care may become episodic to address specific needs. It is also recommended that individuals and their caregivers be educated on the reality of their feeding disorder and be given realistic goals and expectations.

For pre-term infants, it is recommended to use non-nutritive suck and oral motor stimulation to improve suck-swallow-breathe coordination, latching, and suction strength and endurance for improved oral feeding. Oral stimulation and oral support increases volume intake, feeding efficiency, and weight gain while decreasing oral feed time, transition time to full oral feeding, and hospital stay length.⁸⁷⁻⁹⁰ Neurostimulation therapies, such as transcranial magnetic stimulation can be effective for post-stroke dysphagia.⁹¹ Positioning modifications can improve swallowing.⁷⁹ It is recommended that nutritional concerns be addressed through a combination of treatments that address food intake such as task oriented training, behavioral interventions, peer

modeling, sensory activities, and parent/ caregiver education .^{75,89,92-94} It has been recommended that individuals weaning from tube feeding can benefit from hunger provocation and behavioral programs.⁸⁹ Skilled care for swallowing and feeding should empower an individual and their caregiver to become independent once a home program is established.

Vestibular Considerations (PTOT-2.8)

PTOT.2.8.A

v1.0.2022

Vestibular dysfunction is typically characterized by dizziness, imbalance, and vertigo. Vestibular disorders are conditions that affect the normal function of the inner ear and the associated nervous system, and how it interacts with the eyes and other systems that help maintain balance. They may range from acute, sub-acute, or chronic states expressed as varying levels of dizziness and imbalance. Some acute conditions can present with very significant symptoms which greatly impact daily functions. These conditions may be accompanied by significant tinnitus, vision impairment, nausea and other complex symptoms.

Consideration of an individual's need for the skilled care of a vestibular dysfunction necessitates determining that the individual presents with a specific problem that significantly limits their ability to perform basic daily tasks safely. Baseline balance, mobility, and fall risk should be assessed at the initiation of an episode of care.⁹⁵ It is expected that an individual will respond appropriately to skilled care in a predicted amount of time. Standardized, valid, balance, mobility and fall risk outcome- and performance- based measures are recommended to be used to demonstrate levels of deficit and appropriate response to care being provided throughout an episode of care (See [PTOT-2.0: Clinical Considerations](#)).

There are general rehabilitation recommendations from clinical practice guidelines for benign paroxysmal positional vertigo (BPPV), vestibular hypofunction, Meniere's Disease and dizziness/vertigo.⁹⁵⁻⁹⁸ It is recommended that usual care for BPPV include procedures for canalith repositioning. Postural restrictions following repositioning are not recommended. It is recommended that skilled care for vestibular hypofunction and dizziness include active strategies that improve gaze stabilization and habituate the individual to the hypofunction. These strategies should be integrated into daily activities. Frequent practice through a home program is highly recommended. It is also recommended that individuals with chronic hypofunction continue their daily home program for up to 6-9 weeks. Skilled care is not regularly recommended for acute imbalance symptoms as a result of Meniere's Disease. Current recommendations appear to suggest that for cases that require in-clinic supervision, weekly care or less often is typically sufficient. Isolated saccadic and smooth pursuit exercises are not recommended. There are not recommendations for manual therapy or other passive treatments in vestibular hypofunction and dizziness. Skilled care should primarily be active in nature with transition to a home program as soon as possible. Any use of passive treatments should be limited to acute stages in an effort to allow better tolerance to active care.

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