CLINICAL GUIDELINES

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

Version 1.0.2023

Effective May 1, 2023

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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PTOT.1.0.A
v1.0.2023

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

The eviCore clinical review criteria provide guidance regarding the determination of medically necessary care during reviews of requests for skilled care coverage. Reviews based on these (eviCore) guidelines consider all clinical information submitted as part of a request. Decisions that are based on these criteria determine a reasonable and appropriate amount of a skilled care benefit to be authorized for a duration of time specified by the individual's health plan (see **Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care (SLP-1.2)**). These decisions do not determine the specific treatments a provider must use. Providers are responsible to create and follow efficacious and reasonable treatment plans that result in an individual's appropriate responses to care.

Please be advised:

- Specific health plan policies and local/national rules may take precedence over these guidelines (see **Rules, Coverage, Benefits, and Mandates (PTOT-1.3)**).
- Evicore Clinical Review Criteria Guidelines are not intended to be used as treatment guidelines and should not be considered synonymous with peer-reviewed clinical practice guidelines or similar published treatment guidelines.
- "PT and "OT" services are not exclusive to only physical or occupational therapist providers. The following criteria and guidelines apply the same to all requests received for review regardless of provider type.

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Definitions (PTOT-1.1)

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The following definitions are provided only to define key terms and concepts within this guideline document to help establish consistent interpretation and understanding. The definitions themselves are NOT criteria for authorization decisions.

Care Levels:

- **Non-Skilled Care** Non-skilled care includes any services or procedures that are routine or that do not involve complex and sophisticated skill or require the judgment of a qualified provider for safety and plan adjustments. This includes any services or procedures being provided that do not address specific, documented, functional deficits in the individual's essential functions of daily living. Examples may include, but are not limited to: care primarily for general wellness, fitness, specific sport or athletic performance and development, recreation or hobbies. 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 healthcare provider furnishes the service.[1]
- **Skilled Care** Skilled physical or occupational therapy care are services provided at such a level of complexity that the services required can only safely and effectively be performed by a qualified healthcare provider. The care is guided by evidence-based practice within the professional scope of the provider, is goal-directed, client-centered, generally occurs within a reasonable period of time, is not routine and results in an appropriate response.[1] Reviews of medical necessity for skilled therapy care generally fall into one of three types of skilled care: habilitative, maintenance or rehabilitative care.
  - **Skilled habilitative care** is generally defined as services that help an individual to keep, learn, or improve functioning required for daily living. Most states have adopted some version of the National Association of Insurance Commissioners (NAIC) definition.[2]
  - **Skilled maintenance care** is service that is required to create, teach 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 visits generally occur infrequently and are only to establish goals and steps of the program with the individual and caregiver. The actual program would be carried out independently by the individual and their trained caregivers. [1]
  - **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). For the purposes of these

guidelines, care to prevent a future injury or debility in the absence of a current functional limitation is not considered as rehabilitative.[1]

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/oncological comorbidities, psychological comorbidities, frailty, cognitive status, socioeconomic status, language and/or cultural barriers, 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); neurological status (radicular symptoms, myelopathy, spasticity, rigidity, or tremors); post-procedural (prolonged procedure, immobilization or activity limitation); or hospitalization.

Determination

A determination is any final decision of a submitted request for skilled care benefit visits. Requests may receive an approval, partial denial or full denial determination based on the review for medical necessity of the information available at the time of the review.

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.

Episode of Care

An episode of care is generally considered as the period of time from the initial evaluation of the specific condition of the individual until they are discharged from care. An official discharge from care may not always happen, and an episode may end due to lack of an appropriate response or a long lapse in care.

Functions of Daily Living

Activities of Daily Living (ADLs) are essential tasks 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 are considered as essential to daily living and include bathing, toileting, dressing, eating, mobility, personal hygiene, grooming, sleep, management of health conditions, and sexual activity.[3]

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

safety management, the care of others, child rearing, communication, driving, household chores, meal preparation, financial management, employment, social interaction, education and essential play (for young children).[3]

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 aides, caregivers, restorative staff, parents, guardians, family, friends, etc) that are assisting them.

Response to Skilled Care

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

- Improvement towards the established function based goals that is meaningful both clinically and statistically (e.g. Minimal Clinically Important Difference, Minimal Detectable Change) through the use of standardized function based, patient reported or performance based outcomes. Improvement in reported outcomes should be over a reasonable period of time similar those established through the validation process of the chosen outcome.
- Marked improvement in standard measures appropriate for the individual's specific problem as it relates to their ability in 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.

Severity

Severity of an individual's functional problems is a measure of how severe, or bad, the problem is. Severity encompasses several variables which may include frequency, duration, intensity and subjective characteristics. Severity ratings or grading can be used to help describe an overall clinical presentation (overall condition or diagnosis) or it can be used to describe individual problems (e.g. pain, weakness, balance, loss of motion). A common way to categorize severity level is through the use of mild, moderate and severe nomenclature. One such example comes from the World Health Organization[4] (It is not the only measure of severity and is provided as an established example only). It is well-established and easily applied when reviewing cases for medical necessity:

- **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.

There are various ways to grade severity and each system will have limitations. 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. Severity will be based on all information provided for review, including any specific rating or grading provided. However, it does not guarantee medical need or authorization of care.

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 (such as systematic reviews and meta-analysis) may also be generally recognized by the relevant healthcare community.[5] **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.

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

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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 provided documenting an individual's problem and its severity will be considered as part of the review process. Decisions of medical necessity will be based on all the clinical information submitted and available to review at the time a case is considered. It is the provider's responsibility to provide the clinical information they feel best demonstrates the level of medical necessity of the care being requested. eviCore Healthcare reviews all information submitted. The following criteria is applicable to all requests regardless of client populations, provider types or specialties. Please refer to **PTOT-2.0: Clinical Considerations** for information on how variability in clinical presentation is considered during the review process.

Initiation of Skilled Rehabilitation/Habilitation Care

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

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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. Non-compliance with a home program due to lack of specific clinic based equipment or facilities is not a reason for continued skilled care. Home programs can be tailored to the individual's situation and capability.

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.

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. 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.

Determination of Dosage of Skilled Care

The number of skilled care visits authorized as part of an individual's health care benefit will be influenced by many factors. Individual clinical presentations will vary; as will the medical need for a certain number of visits. Individual health plan policies and visit limitations will vary and must be followed. A dosage of skilled care visits should be based on medical need; not specific to a diagnosis, procedure, protocol or treatment method. It is eviCore's intent that the amount of services authorized for a request are reasonably sufficient for the entire duration of that request's time period.

The following is meant to apprise clinicians of the various general (but not limited to) considerations involved in deciding on a reasonable number of visits to authorize for a request. It only serves as background guidance into dosage considerations and is

subject to individual and case by case variability. The exact number of visits per request will vary based on these considerations and is not predictive. The following does not supersede or take place of the medical necessity criteria just established in section 1.2. All case decisions will be made based on the clinical information available at time of the review:

Response / Likelihood of response – Skilled care must drive an appropriate response. It is reasonable that individuals responding rapidly to care would warrant more frequent clinical visits than those responding slowly. Clinical based treatments and programming should be commensurate with the individual's readiness for significant progressions. A reasonable number of clinical visits would encompass reasonable time between visits for the individual to sufficiently practice their home program on their own enough to require new updates or modifications. A consistent lack of progress or decline would indicate treatment is becoming ineffective. Once care is no longer effective, continued skilled care would not be reasonable.

Severity – Individuals with more severe dysfunctional presentations (moderate to severe) may benefit from more skilled care than those with less severe presentations (minimal to mild). The severity of an individual's functional deficit is of primary concern when considering the need for the use of a skilled care benefit; as the purpose of a skilled care benefit is to manage ability levels. Individual complexities and complications may make for more severe functional problems and those identified in the submitted clinical information will be a consideration in dosage decisions.

Chronicity – Chronic conditions, outside of acute exacerbations, are more constant and change very slowly or not at all. Reasonable skilled care for chronic conditions often involves infrequent episodes of care where a small number of visits are used for a short time to address acute problems. The individual (with any caregivers) can then focus on the practice of their program and maintaining healthy habits on their own for a time.

Healing Time Frames – Tissue damage, such as an injury, surgery or wound, requires physiologic healing over time. Healing time frames will vary depending on the extent of tissue damage, health of the tissue and health of the individual. Acutely healing tissues may be too delicate to tolerate frequent skilled care. Individuals with recalcitrant healing may benefit from a block of regular skilled care.

Caregiver Training – Many individuals receiving skilled care will require assistance from a caregiver to complete basic daily tasks. Consideration of the individual's functional age level and ability to understand and follow a home program would be encompassed as part of caregiver training. It is reasonable that some clinical time will be needed to provide caregiver training. A reasonable amount of caregiver training will vary by case, but is not expected to require extensive or intensive clinical time. However, continued care due to a lack of a caregiver does not meet the definition of skilled care.

Post-procedural Care – More frequent skilled care visits may be needed initially following major surgical procedures. The resultant functional ability level of the individual following the procedure is a key component to dosage decisions. As recovery progresses, the individual (and caregivers) typically becomes more independent with

basic daily tasks and their home program thus reducing the need for frequent skilled intervention. A dosage of visits authorized for any request will not be based on just a procedure, post-procedural protocol or similar, but on a case by case basis.

Strength – It is generally accepted that strength adaptations take at a minimum several weeks and require an appropriate intensity of exercise. Reasonable plans of care would involve exercise programs that are progressive so that intensity is maintained. However, repetition of exercises or skills is also a key component to progress. Individuals are responsible to practice said programs consistently outside of clinical visits. Practice need not always be perfect or require extensive feedback. Decisions on a number of skilled care visits takes into account that individuals need time between clinic visits to practice and adapt to the program they were given.

Evidence Based Recommendations – Currently, research on establishing the most efficacious dosages of skilled therapy is minimal. Research is adequate to show that skilled care can be generally effective. It is not adequate to show what number of visits is a superior dosage in most clinical situations. Some published research and guidelines may give recommended visit ranges, however these are often quite wide and vary by source so can only be used as general starting points to consider. eviCore does review current research literature but must consider all individual clinical factors when deciding upon a range of visits to authorize.

National Practice Patterns – National skilled care visit data can reveal usage patterns, including average visit dosages. These averages can function similar to recommended visit ranges from clinical research and help provide consistent visit numbers to consider while all the clinical information in a request is reviewed.

Initial requests – It is reasonable to expect that starting a new treatment plan (not re-evaluation or continuation after lapse in care) can be more involved and may require additional attention from a skilled provider than compared to blocks of care from subsequent requests. It is assumed initial visits will be used to start care, educate the individual, start a home program, and train caregivers. Also, that there will be a reasonable block of initial visits for clinical sessions to monitor how the individual responds to the plan of care. For some clinical presentations it may be reasonable that the initial block of visits would be sufficient to complete the entire episode of care.

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)

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eviCore must take into consideration and follow any applicable exclusions, 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. Providers and individuals need to reference health plan policies and rules, federal or state health mandates, and any other applicable policies for any concerns about covered and non-covered skilled care services.

Health plans may be administered privately (commercial) or through state or national administrators (e.g. Medicare, Medicaid). 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 will take precedence over eviCore's medical necessity criteria. Private health plans may have specific limitations on how skilled care benefits are administered which dictate aspects of a request such as time frames allowed for submitting requests, when an authorization will expire, how long an episode of care may have coverage, benefit maximums, non-covered exclusions, and how a request can be submitted to eviCore.

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.[6] Similarly, Medicaid based health plans are state specific. They may be administered through the state health department or through administrators appointed by the state. Either way, Medicaid policy take precedence over eviCore Healthcare policy.

Applicable federal or state health mandates can 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.

All determinations complete by eviCore will be communicated to the appropriate stakeholders as dictated by the health plan or policy in force. While there may be some variation, this typically includes at least the requesting provider, the member and referring provider if applicable. The determination letters should provide any authorized number of visits or denial of visits, a rationale for the decision and the guideline/policy that applies to the decision. The determination letters will also communicate any

additional rights and points of contact for that decision. It is the provider's responsibility to read determination letters.

Clinical Considerations (PTOT-2.0)

Clinical Considerations (PTOT-2.0)

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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 individuals, conditions, diagnoses and limitations as to why an individual could seek skilled care and what could be a reasonable amount of care. There are different areas of discipline (e.g. integumentary, lymphatic, neurologic, orthopedic, pediatric, pelvic, etc), and concentration or specialty (e.g. manual therapy, aquatic therapy, geriatrics, hand therapy, etc) 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. There may be specific precautions and timelines in relation to medical procedures to consider. This section and its subsections provide supplementary language to help establish what can be considered as reasonable evidence based care and an appropriate response to care while keeping in mind possible variations. The sections are organized based on common body system areas and are not diagnosis specific. An Individual's clinical presentation may fall into more than one section.

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, patient reported outcomes 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. [7-9] There are many validated standard measures and assessments available for a variety of functional deficits, conditions, diagnoses, ability levels, risk levels and population groups. 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.[10-12] 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 and additional information can be sent with any request.). It is acknowledged that standard measures are not free from some levels of subjectivity, bias and error. Additional clinical information beyond standard scores can help inform

on the individual's complete situation and problems. All pertinent and applicable clinical information documenting an individual's progress is considered during the review process. (**PTOT-1.1: Definitions**)

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 recommendations based on published, credible, high-level, scientific, evidence-based clinical practice guidelines and systematic reviews of applicable research; they 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, an individual's 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. An individual clinical trial may show a particular treatment or technique is effective for a specific problem and population, however just using a researched treatment is not what determines if an episode of skilled care is medically necessary.

Integumentary Considerations (PTOT-2.1)

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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.[13] 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.[14] The five etiologies of burns include: thermal, chemical, electrical, radiological, and cold exposure.[15] 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. [14-17]

The tracking of tissue health 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.[18] 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.[19] 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.[20] 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, we look for reasonable progress in would healing over a 30 day period of time.

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.[14-17]

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.[21,22] 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 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. Current recommendations state that skilled wound management should encompass effective therapeutic interventions and the eventual transition to a self-management program. There is a wide range of dressings and treatments recommended for wounds and burns.[14,16,17,20-22] Validated research based therapeutic interventions for the treatment of wounds and burns include the use of: cleansing, sharp debridement, pulsed lavage with suction, negative pressure wound therapy, biophysical agents, electrical stimulation, application of Unna boots, contact casting, splints, short stretch bandaging, dressings and multilayer bandaging.[14,16,17,20-24] Phototherapy (UVA, UVB, UVC) can be an effective treatment for skin conditions such as eczema, psoriasis and vitiligo.[25-28] Home programs for self-management may include tissue hygiene maintenance, compression treatment, contracture management and off-loading orthotics/devices once the wound is stabilized, routine wound cleansing and dressing changes. Patient education regarding long-term maintenance and self-management should include patient specific strategies, including tissue hygiene maintenance once the condition is stabilized.[14,16,17,22-28]

Lymphatic Considerations (PTOT-2.2)

PTOT.2.2.A
v1.0.2023

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.[29] 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**).

Current peer-reviewed recommendations suggest commencing skilled care when limb volume is demonstrating regular asymmetrical swelling of approximately >5% in the upper extremity or >10% in the lower extremity.[30] 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.[31]

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. Current recommendations correlate with what stage of lymphedema an individual is experiencing.[29,30] The less severe stages may only require self-care, occasional monitoring, elevation and/or compressive garments.[30,32] As the edema progresses in severity, an episode of skilled care for complete decongestive therapy (CDT) is recommended.[29-33] Treatment generally consists of two phases: Decongestive and maintenance. CDT encompasses physically active strategies (e.g. elevation, exercise), 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 includes 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.

Musculoskeletal Considerations (PTOT-2.3)

PTOT.2.3.A
v1.0.2023

Musculoskeletal (MSK) conditions are typically characterized by pain and limitations in mobility, strength, coordination, and balance, leading to functional deficits in activities of daily living. 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.

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; skilled care may not always be necessary for all MSK conditions[34-38]. 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 any specific post-surgical protocols, phases of recovery and applicable differences in surgical technique.

Recommendations from published high-level guidelines and systematic reviews for many common MSK conditions suggest that when skilled care for an individual with an MSK problem is medically needed it 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.[34-64] Strong recommendations have been made that services should be customized to the individual.[41-63] The evidence recommends that individuals be provided with progressive home and self-care programs so they can regularly work on the routine aspects of their care on their own and become independent with their own care long term.[34,37,39-45,49,50-64] Establishing a plan for independent long term self-care and exercise is especially recommended for individuals with conditions of chronic pain. [44,47,51,54,60] There is

moderate-level evidence to support the use of combining short term manual therapies when appropriate with active solutions as part of a comprehensive program.[39,41,44,51,58,62,64]. Recommendations on the regular use of passive physical agents are very limited which would suggest these modalities have very limited benefit to any functional progress of the individual.[34-64]

Neurological Considerations (PTOT-2.4)

PTOT.2.4.A
v1.0.2023

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. Neurological 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 neurological 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 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.[65-77] Their recommendations suggest 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.[66,68-74] The literature recommends that skilled care primarily focus on active motor strategies and patient/caregiver education that addresses specific disabilities and goals with empowerment on transitioning to a home program. Strong recommendations have been made that caregivers should be involved during all stages of an episode of care.[69,70,72,74] There is good evidence to support the benefit of targeted exercise and training on mobility problems.[66,68,69,71,73-75] There has been increased recommendation 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.[65-77] Recommendations for the use of passive treatments and techniques to improve function during neurological skilled care are very limited. Evidence to support the regular use of body-weight support training, robotic/exoskeleton support training, and vibration plates is currently inconclusive. Individuals can learn a home program with their caregivers and repeat their program between in-clinic sessions.[69,70,72,74,75] 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.[65-77]

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.[76,77]

Current best evidence recommends that individuals with progressive disease may need access to periodic 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 significant progression of disease. Encouraging self-management with realistic expectations is recommended.[66,68-71,74,75]

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 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.[72]

Pediatric Neurodevelopmental Considerations (PTOT-2.5)

PTOT.2.5.A
v1.0.2023

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.[78,79] Baseline standardized testing of milestone attainment and deficits in essential tasks should be assessed at the initiation of an episode of care.[78-80] 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. Appropriate measures should be used at regular intervals to track the response to care being provided (**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.

Pediatric individuals with a 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.[78-80] Complexities and complications may arise due to other medical procedures, surgeries or medication changes.[81] 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.

Current peer reviewed guidelines recommend skilled care for individuals presenting with pediatric neurodevelopmental conditions should be task oriented.[78-84] 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].[82, 84] Goals should be developed collaboratively with the

child and parent/caregiver at increments appropriate for the child's level of ability and progress. The goal oriented skills can be practiced in the home and community environments and updated appropriately. Skilled care should be enjoyable and motivating to the child.[78-80,82-84] In addition, there are strong recommendations for parents/caregivers to be taught appropriate play and developmental activity strategies through coaching and education.[79, 84] 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.[83] 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.[82] Adaptive equipment and assistive technology may be beneficial.

Pelvic Considerations (PTOT-2.6)

PTOT.2.6.A
v1.0.2023

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 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**).[85,86,88,89] Due to the intimate nature of functions related to the pelvic region, some dysfunctions may also be monitored through patient reported 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.[85-90]

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.[86,87] 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.[85-90] Strong recommendations have been made that skilled services be customized to the individual and include active strategies such as pelvic floor muscle training and increasing physical activity as first line skilled care options.[85-90] Familiarity with current exercise recommendations and contraindications for individuals during the antepartum period is strongly supported.[86,90] It is recommended that individuals be empowered to complete a regular home program that is tailor to the individual's needs. Home programs incorporate active treatments into daily life.[85-90]. Use of manual therapies may be beneficial as a short term adjunct to facilitate active strategies.[86] Evidence for the general use of passive treatment modalities 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.[88,89] Passive treatments; during acute stages may allow better tolerance to active care, but is not supported by published guidelines to be the majority of care provided.[85-90]

Swallowing and Feeding Considerations (PTOT-2.7)

PTOT.2.7.A
v1.0.2023

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**).[78,79] 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.[79,80,83] 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.[91-94] Neurostimulation therapies, such as transcranial magnetic stimulation can be effective for post-stroke dysphagia.[95] Positioning modifications can improve swallowing.[77] 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 .[73,93,96-98] It has been recommended that individuals weaning from tube feeding can benefit from hunger provocation and behavioral programs.[93] 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
v1.0.2023

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. Dysfunction of associated regions such as the neck, central or peripheral nervous systems may also contribute to dizziness. 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.[99] 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, dizziness/vertigo and cervicogenic dizziness.[99-102] 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 and may be needed for long term management. Current best evidence recommends that skilled care for acute imbalance symptoms as a result of Meniere's Disease may not be efficacious. Current recommendations appear to suggest that in-clinic supervision be spaced out to allow sufficient time for practice of a home program. The current research does not recommend Isolated saccadic and smooth pursuit exercises. 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. Recommendations for cervicogenic dizziness include active exercise techniques combined with limited manual therapy to address associated mobility issues. 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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