CLINICAL GUIDELINES

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

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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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Clinical Review Criteria: Physical Therapy (PT) and Occupational Therapy (OT) Services (PTOT-1.0)

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Clinical Review Criteria: Physical Therapy (PT) and Occupational Therapy (OT) Services (PTOT-1.0)

PTOT.1.0.A
v1.0.2025

PTOT-1.0: Clinical Review Criteria: Physical Therapy (PT) and Occupational Therapy (OT) Services

The EviCore therapy service clinical review criteria provide guidance regarding the determination of medically necessary care during reviews of requests for skilled therapy. EviCore's therapy clinical reviewers consider all clinical information submitted as part of a request as they follow these guidelines in making a determination. Decisions using these criteria determine a reasonable amount of a skilled care benefit to be authorized for a specific duration (see **Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care (PTOT-1.2)**). A determination takes into account the "dynamic interaction between a person's health condition, environmental factors, and personal factors," as detailed within the International Classification of Functioning, Disability and Health (ICF)[1]. EviCore does not determine the specific therapy treatments or services a provider must use during clinical visits. Providers are responsible to create and follow efficacious and reasonable treatment plans that result in an individual's appropriate responses to care using the amount of visits determined over the time period allowed.

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 PT and OT Clinical Review Criteria Guidelines are not intended to be used as provider treatment guidelines and should not be considered synonymous with peer-reviewed clinical practice guidelines or similar published treatment guidelines.
- The following guidelines apply the same to all skilled therapy medical necessity reviews regardless of provider type, so long as skilled therapy is within the legal scope of that provider.

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Definitions (PTOT-1.1)

PTOT.1.1.A
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The following definitions are provided by EviCore Healthcare 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 and that do not involve complex and sophisticated skill requiring the judgment of a qualified healthcare 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. 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.[2]
- **Skilled Care**

  Skilled 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, is client-centered, occurs within a reasonable period of time, is not routine, and results in an appropriate response.[2] The services may include formal evaluations/re-evaluations, formal treatments, periodic assessments, home or independent program prescription and caregiver training. The care takes into consideration the member's activity level and ability to actively participate in their daily tasks in their current environment. Skilled therapy care generally falls into one of three types: habilitative, maintenance, or rehabilitative care.
  - **Skilled habilitative care** is generally defined as services that help an individual keep, learn, or improve functioning required for participation in meaningful daily activities per their individual personal role. Most states have adopted some version of the National Association of Insurance Commissioners (NAIC) habilitation definition.[3]
  - **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 to allow for "maximal" (realistic) participation in daily activities. Skilled maintenance care

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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. [2]

- **Skilled rehabilitative care** are services designed to address the improvement in functional limitations of an individual's body and/or structure (associated with an injury, disability, wound, disease or other condition), while additionally addressing any limiting environmental or personal factors that are necessary to return the individual to a reasonable activity level required to participate in 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.[2]

Complexities / Complications

Individuals may present with any variety of situations, impairments 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: body function/structure (physical/psycho-social comorbidities), environmental factors (support systems, accessibility products and technology), and personal factors (language/cultural factors, age, attitude).[1]

An individual may also experience any variety of new problems or circumstances that directly complicate the current impairment 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 sequelae (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.

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.

Experimental, Investigational, or Unproven (EIU)[4]

Certain studies, treatments, procedures, or devices may be considered experimental, investigational, or unproven for any condition, illness, disease, or injury being treated if one of the following is present:

- if there is a paucity of supporting evidence;
- if the evidence has not matured to exhibit improved health parameters;
- if clinical utility has not been demonstrated in any condition; OR
- if the study, treatment, procedure, or device lacks a collective opinion of support.

Supporting evidence includes standards that are based on credible scientific evidence published in peer-reviewed medical literature (such as well conducted randomized clinical trials or cohort studies with a sample size of sufficient statistical power) generally recognized by the relevant medical community. Collective opinion of support includes clinician specialty society recommendations and the views of clinicians practicing in relevant clinical areas when specialty society recommendations are not available.

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.[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 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).[5]

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.

Medically Necessary[3]

Healthcare services or supplies needed to diagnose, treat, or evaluate a condition or prevent an injury, illness, condition or disease that meets accepted standards of medicine based on evidenced-based clinical standards of care based on supporting evidence and/or collective opinion of support that is:

- Clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the individual's illness, injury, or disease;
- Clinical utility of the technology, device, treatment, or procedure has been demonstrated for a diagnosis, treatment, evaluation of an illness, condition, or disease based on evidence-based clinical standards of care;

- Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of a condition;
- Not primarily for the convenience of the individual seeking medical services, health care provider, or other physicians or healthcare providers;
- Supporting evidence and/or collective opinion of support does not demonstrate that there is an alternative that is more appropriate/effective for diagnosis, treatment, or evaluation of a condition.

Response to Skilled Care

An appropriate and significant response to *skilled rehabilitative care* may be demonstrated through a documented combination of:

- Marked improvement in the established function-based goals that is meaningful both clinically and statistically (e.g. Minimal Clinically Important Difference, Minimal Detectable Change). The improvement should be shown through the change in standard outcome measure scores. Improvement in outcome measure scores should be over a reasonable period of time similar to those published in research-based validations of the chosen outcome. Standard outcome measures are any measure that has been validated through research and has a standardized method of obtaining scores. These could be patient-reported outcome surveys (i.e. the individual completes a survey about their current function and a score is tabulated from their responses) and/or performance-based measures (i.e. the individual performs a standard set of tasks that are scored by the observing clinician).
- Marked improvement in clinical assessment-based measures appropriate for the individual's specific problem as it relates to their ability in daily life, such as reliably quantified mobility/ability levels, ranges of motion, functional strength measures 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 (e.g. walking distance, time to complete tasks at home, radicular sensation reduction, sensory improvements).

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 functional impairments and participation limitations.
- 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 habilitative care* may be demonstrated through:

- A documented need for skilled care by a qualified provider based upon appropriate improvement from norm-referenced standardized testing, criterion-referenced standardized testing and/or functional performance.
- Clear documentation of newly gained acquisition of skills or independence of functional tasks directly associated with the established goals in the plan of care.

Please reference the Clinical Consideration section **PTOT-2.0: Clinical Considerations** below for additional information regarding the use of standard 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 personal and environmental factors. Severity ratings or grading can be used to help describe an overall condition, diagnosis, or it can be used to describe individual impairments (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[1]. 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.
- **Permanent problem -** The problem is present all of the time (96% or greater) and frequently alters daily life. A permanent problem is no longer changing.

There are various ways to grade severity and each individual system will have limitations. Severity grading helps to provide context to the impairments and limitations 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, standards of practice are widely accepted clinical practices supported by recommendations in published peer-reviewed evidence-based clinical practice guidelines. In the absence of guidelines for a specific area of practice, a collection of peer-reviewed high-level research literature (such as systematic reviews

and meta-analysis) may also be generally recognized by the relevant healthcare community.[6] See section **PTOT-2.0: Clinical Considerations.**

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

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

PTOT.1.2.A
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Due to the complex nature of any individual's diagnosis, complexities and complications, and environmental and personal factors decisions of medical necessity will be based on all the clinical information submitted and available to review at the time a case is considered. Each request submitted for review must have clinical information that, at a minimum, demonstrates the individual's current impairments and limitations in ADLs/ IADLs demonstrated through standard quantifiable measures. For the convenience of the provider when going to submit clinical information for review EviCore has clinical worksheets available at www.evicore.com. The worksheets show what information should be submitted with a request. The worksheets also provide examples of some common standard measures. Not all possible measures are listed on the worksheets. Providers are responsible to choose appropriate standard measures for the individual's situation. There are multiple worksheets available and a provider may choose the most appropriate form based on the individual's type of impairment or concern.

If subsequent requests for an individual are submitted, these requests should be accompanied by clinical information that, at a minimum, demonstrates how the individual has responded to the care provided according to changes in standard quantifiable measures and goals, and that significant limitations remain that have not yet been addressed. Formal re-evaluations may be necessary when an individual presents with significant changes in their impairments due to new complications, complexities or significant gaps in care requiring the skilled assessment of a provider leading to an updated plan of care. This does not necessitate that a provider do a formal re-evaluation for every request, as clinical measures should be taken and goals updated periodically throughout a course of an individual's care. 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.

The following criteria is applicable to all requests regardless of client populations, provider types or specialties. Please notice that some criteria is specific to the type of skilled care being provided (habilitative, maintenance, or rehabilitative).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

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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. Meets the definition of "Medically Necessary" as defined previously in section **PTOT-1.1: Definitions**
2. The skills of a qualified provider are required to address a documented significant specific functional impairment in participation of 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 an appropriate 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 primarily related to continued participation in elective activities that are beyond essential daily tasks.
   c. The care is not primarily passive, not routine, or can reasonably be done by the individual, caregivers or other non-skilled professionals (i.e. staff, trainer, coach, family).
3. 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 limitations and would not be considered experimental, investigational or unproven (EIU) (See Generally Accepted Standards of Practice and EIU in **PTOT-1.1: Definitions**).
4. 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).
5. 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 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 services to create a maintenance program or maintain an individual's condition will be considered medically necessary 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. Meets the definition of "Medically Necessary" as defined previously in section **PTOT-1.1 Definitions.**
2. The maintenance program/care require such complexity and sophistication that only a qualified provider can address them safely. The skills of a qualified provider are required for either of the following:
   a. To establish or design a customized maintenance program to be carried out by the individual and their caregivers appropriate to their capacity and tolerance. The individual's current functional status is no longer rapidly changing, but should be maintained to promote safety, current activity level or slow deterioration, and there has not yet been a reasonable opportunity to establish a program, or
   b. To address the best course of management of the individual who is experiencing special medical complications until they are more stable or can follow a home program (i.e. an individual with an unstable fracture that requires skilled passive range of motion).
3. 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 limitations and would not be considered experimental, investigational or unproven (See Generally Accepted Standards of Practice in **PTOT-1.1: Definitions**).
4. 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, including potential formal re-evaluations or assessments, (habilitation/rehabilitation/maintenance) beyond the initial determination 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, 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**) but the skills of a qualified provider are still required to address some remaining specific significant functional impairments.

   -OR-

   The individual has a significant acute decline in their function related to impairments that have not previously been addressed during the current episode of care (flare up,

following a significant gap in care, etc.) that has resulted in a clinically meaningful deficit in ADL/IADL participation 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 in one of the following scenarios:

a. There has been a new exacerbation of symptoms despite adherence to the plan of care, but the individual was otherwise responding appropriately.
b. Progression of the impairment 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 meet the definition of "medically necessary" as previously outlined.
3. The services provided continue to be at an appropriate skill level and are progressive in their programming according to either of the following:
   a. The services are not routine 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. New functional skills are being addressed as the plan of care is progressed over the episode.
   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 to carry out a care program does not apply.
4. 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 dose of visits. Individual health plan policies and visit limitations will vary and must be followed. A dose of skilled care visits should be based on medical need and not be specific to only 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 general (but not limited to) considerations involved in deciding on a reasonable number of medically necessary

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visits to authorize for a request. It serves as background guidance into dosage considerations and is subject to some case-by-case variability. The exact number of visits authorized per request may 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 **PTOT-1.2**.

Response / Likelihood of response – Skilled care must drive an appropriate response by the individual. It is reasonable that, in general, individuals responding rapidly to care would be ready for more frequent skilled progression and updates than those that respond more slowly. Clinical based treatments and programming should be commensurate with the individual's readiness for significant progressions. A reasonable number of clinical visits will take into account reasonable time between visits for the individual to sufficiently practice their home/self-care program on their own so they are ready for new updates or modifications during a subsequent visit. A consistent lack of progress or decline (not to be confused with an acute complication) may indicate treatment is becoming ineffective. Once care is not effective, continuing with the same plan of care would not be reasonable.

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 the 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

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 impairment 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 activity and participation levels. Individual complexities, complications and personal and environmental factors 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 impairments and establish a self-care program. The individual (with any caregivers) can then focus on the practice of their program and maintain healthy habits on their own for a time. This is sometimes referred to as episodic care.

Healing Time Frames – 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

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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 varying levels of assistance from a caregiver to complete basic daily tasks. 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 it should not require extensive or intensive clinical time. Continued care due to 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 activity and participation 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.

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 baseline 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. It is assumed initial visits will be used to start care, educate the individual, start a home program, and train caregivers. It is also assumed that there will be a reasonable block of visits for clinical sessions to monitor how the individual responds to the plan of care. For some clinical presentations it is reasonable that the initial block of visits would be sufficient to complete the entire episode of care. It is reasonable to expect that initial authorized visits are used judiciously.

Subsequent Requests (AKA Follow-up requests) - Where criteria is met for continued skilled care, an individual may still demonstrate medical necessity for care following the

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use of visits from an initial request. However they would be more familiar with their self-care program and their significant functional impairments should have been addressed. As an individual responds appropriately to care over a reasonable timeframe their ability to self-manage should increase. It is reasonable to expect that the frequency of skilled care visits will be adjusted as the severity of the individual's limitations change.

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.

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

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EviCore is required to follow any applicable exclusions, rules, policies or mandates set forth by the health plan or governing bodies when processing requests for skilled care. Specific rules pertinent to submitting a request for skilled care will vary by health plan. The final determination of reimbursement for skilled therapy services is at the discretion of the health plan. Benefit, coverage policies, and eligibility issues pertaining to each health plan and/or jurisdiction may take precedence over EviCore's guidelines. When EviCore completes a case review for an individual that is covered by a Centers for Medicare and Medicaid Services (CMS) health plan that specific CMS policy would apply. Please refer to our CMS Policy Hierarchies and Application for further details. [7]

All determinations completed 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.

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Clinical Considerations (PTOT-2.0)

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Clinical Considerations (PTOT-2.0)

PTOT.2.0.A
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EviCore takes into account current scientific evidence-based recommendations when evaluating a request for an appropriate need for skilled care. There are many variations in individuals, health conditions, diagnoses, functional limitations and environmental factors as to why an individual could seek skilled care and be authorized for a reasonable amount of care. There are different areas of discipline (e.g. orthopedic, pediatric, pelvic, neurologic, lymphatic, integumentary, etc.), and concentration or specialty (e.g. manual therapy, hydrotherapy, geriatric, etc.) within skilled care; these differences will be part of the clinical context considered during a review. Effective treatment options vary from individual to individual and case to case. 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 activity and participation level than on specific treatments or techniques. Just because a treatment or method has been shown to be effective in research does not mean it is medically needed. This section (PTOT 2.0) provides supplementary language to help establish what current best-evidence recommends as reasonable standards of care while still keeping possible variations in mind. 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**. Demonstrating an appropriate and significant response to skilled care is required throughout an episode of care to show a continued need of care (See Appropriate Response to Skilled Care in **PTOT-1.1: Definitions**). Measures used should reflect the condition and goals of the individual.[8-10] It is the skilled provider's professional responsibility to choose appropriate standard measures specific to the needs and goals of the individual under their care as well as to know how to administer, score and track the chosen measures.[8-13] 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.

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 submitted documenting an individual's progress is considered during the review process.

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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.[14] 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/stage, tissue type with percentage, exudate characteristics, wound edge characteristics and distinctive characteristics (including, but limited to tunneling, undermining, and hypergranulation) 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. [14,15]

The tracking of tissue health over a given period of time will help determine when continued skilled care is recommended. There are 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.[16,17] 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

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is unlikely.[18] 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.[19] 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 wound healing over a 30-day period.

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.[14-18]

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 disorders 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.[14,16-20] 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 are a wide range of dressings and treatments recommended for wounds and burns.[14-21]

Validated research based therapeutic interventions for the treatment of wounds and burns include the use of: debridement, pulsed lavage, ultrasound, negative pressure wound therapy, electrical stimulation, compression systems, contact casting, off-loading devices, pressure redistribution, splints and dressings.[14-20] Phototherapy (UVA, UVB, UVC) can be an effective treatment for skin conditions such as eczema, psoriasis

and vitiligo.[21-24] Home programs for self-management may include wound cleansing, dressing changes, tissue hygiene maintenance, compression treatment, contracture management and pressure redistribution. The transfer of wound care to the individual is expected once the wound reaches a state at which its care can be performed primarily by the individual with periodic provider assessment and supervision. Education regarding long-term maintenance and self-management should include patient-specific strategies, including tissue hygiene maintenance once the condition is stabilized.[14-20]

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

Lymphatic Considerations (PTOT-2.2)

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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.[25] 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.[26] Multiple measurements of excessive volume over time help demonstrate 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.[27]

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.[25,26] The less severe stages may only require self-care, occasional monitoring, elevation and/or compressive garments.[26-28] As the edema progresses in severity, an episode of skilled care for

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complete decongestive therapy (CDT) is recommended.[25-30] 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, appropriate manual lymphatic drainage, and the application of multi-layer compression bandages or the use of a "reduction kit" to the affected area. 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.

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

Musculoskeletal Considerations (PTOT-2.3)

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Musculoskeletal (MSK) conditions are typically characterized by pain and limitations in mobility, strength, coordination, and balance, leading to functional deficits in ADL and IADLs. 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 skilled care of an MSK condition necessitates determining that an individual presents with a specific limitation that significantly limits their ability with ADLs/IADLs; skilled care may not always be necessary for all MSK conditions. The individual's function should be assessed at the initiation of an episode of care and regularly throughout an episode. It is expected that an individual will respond appropriately to skilled care in a reasonable and generally predictable amount of time.

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, and patient and caregiver education that address specific disabilities and goals, as well as use of valid outcome- and performance-based measures.[31-64] Strong recommendations have been made that services should be customized to the individual.[36-38,40-42,44,47-64] 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 program and become independent with their own care long term.[31-35,37-42,44,45,48-56] Establishing a plan for independent long-term self-care and exercise is especially recommended for individuals with conditions of chronic pain.[34,36-38,41-43,46,47-50,53-61] 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.[36-64] 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.[31-64]

Skilled care for the individual may be in relation to a limitation in ADL/IADLs because 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. While the above recommendations often still apply to post-surgical skilled care there may be

additional considerations in assessing the needs of the individual. Surgical approaches and technique will vary. Each individual will respond to their procedure differently. A need for skilled care should be based on the complete clinical scenario presented that meets the indications for care including consideration of associated healing time frames, complexities, complications, phases of recovery and applicable differences in surgical technique.[31-36,28,39,42,43,45-47,58,59,62]

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

Neurological Considerations (PTOT-2.4)

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Neurological conditions are typically characterized by limitations with ADLs/IADLs, such as mobility, strength, coordination and balance limitations, due to nervous system dysfunction. Individuals with neurological 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 affect 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 neurological 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 neurological condition may improve ability in ADLs/IADLs quickly over time, whereas 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. 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. 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. The neurological presentation of an individual 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

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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. These 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.[65-79] 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.[65-79] There is good evidence to support the benefit of targeted exercise and training on mobility problems.[65-79] 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.[66,68,71,73,76,77] Recommendations for the use of passive treatments and techniques to improve function during neurological rehabilitation are very limited. Evidence to suggest the necessity of the regular use of body-weight support training, robotic/exoskeleton support training, and vibration plates is inconclusive.[71,73,76] 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.[65-79]

Sensory dysfunction as part of any neurological condition can negatively affect an individual's ability with ADLs/IADLs. Current research primarily 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.[78-79]

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 optimize an individual's functional status given any new progression of disease. Encouraging self-management with realistic expectations is recommended.[66,68,69,72-77]

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.[72,80,81]

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

Pediatric Neurodevelopmental Considerations (PTOT-2.5)

PTOT.2.5.A
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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.[80-82] Baseline standardized testing of milestone attainment and deficits in essential tasks should be assessed at the initiation of an episode of care.[80-82] 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, Alberta Infant Motor Scale, Peabody Developmental Motor Scales]. 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.[80-82] Complexities and complications may arise due to other medical procedures, surgeries or medication changes.[83] 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.[80-86] Strong evidence

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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].[80-86] 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.[80-82,84-86] In addition, there are strong recommendations for parents/caregivers to be taught appropriate play and developmental activity strategies through coaching and education.[81,82,85,86] 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.[82,85] 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 may benefit from skilled care that aims to improve their contributions to everyday tasks through small actions and changing environmental factors with the use of adaptive equipment to support function and inclusion.[84] Adaptive equipment and assistive technology may be beneficial.

Pelvic Considerations (PTOT-2.6)

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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 process. 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**).[87-92] 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.

Gynecological, urological, gastrointestinal, or colorectal surgical interventions may be used to help correct a pelvic dysfunction; the pelvic dysfunction may also 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

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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.[88,91,93] These complications, and any associated interventions, can vary significantly from one individual to another. An individual's need for skilled care related to pregnancy and postpartum recovery will be assessed on a case-by-case basis 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.[87-93] 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.[87-93] Familiarity with current exercise recommendations and contraindications for individuals during the antepartum period is strongly supported.[88,91,93] It is recommended that individuals be empowered to complete a regular home program that is tailored to the individual's needs. Home programs incorporate active treatments into daily life.[87-93] Use of manual therapies may be beneficial as a short-term adjunct to facilitate active strategies.[87-92] 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.[89,90,92,93] Passive treatment during acute stages may allow better tolerance to active care, but is not supported to be the majority of care provided.[87-93]

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Swallowing and Feeding Considerations (PTOT-2.7)

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Swallowing and feeding disorders are typically characterized by impaired oral intake that is not age-appropriate, effective 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**).[81,82,94,95] 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 provides 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.[81,82,94,95,97] 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.[94,95,97] Neurostimulation

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therapies, such as transcranial magnetic stimulation, can be effective for post-stroke dysphagia.[98] Positioning modifications can improve swallowing.[81-83] It is recommended that nutritional concerns be addressed through a combination of treatments that address food intake such as task-oriented training, behavioral interventions, modeling, sensory activities, and parent/caregiver education.[82,99-104] It has been recommended that individuals weaning from tube feeding can benefit from hunger provocation and behavioral programs.[104] Skilled care for swallowing and feeding should empower an individual and their caregiver to become independent once a home program is established.

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

Vestibular Considerations (PTOT-2.8)

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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 and central or peripheral nervous systems may 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 limitation 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.[105-109] 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, cervicogenic dizziness and Meniere's Disease.[105-108] It is recommended that usual care for BPPV include procedures for canalith repositioning. 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 suggests that skilled care for acute imbalance symptoms as a result of Meniere's Disease may not be efficacious.[109] 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

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passive treatments should be limited to acute stages in an effort to allow better tolerance to active care.[105-108]

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