



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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Table of Contents

Guideline	Page
Clinical Review Criteria: Physical Therapy (PT) and Occupational Therapy (OT) Services (PTOT-1.0)	3
Clinical Review Criteria: Physical Therapy (PT) and Occupational Therapy (OT) Services (PTOT-1.0).....	4
Definitions (PTOT-1.1).....	5
Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care (PTOT-1.2).....	11
Rules, Coverage, Benefits, and Mandates (PTOT-1.3).....	18
Clinical Considerations (PTOT-2.0)	19
Clinical Considerations (PTOT-2.0).....	20
Integumentary Considerations (PTOT-2.1).....	22
Lymphatic Considerations (PTOT-2.2).....	25
Musculoskeletal Considerations (PTOT-2.3).....	27
Neurological Considerations (PTOT-2.4).....	29
Pediatric Neurodevelopmental Considerations (PTOT-2.5).....	32
Pelvic Considerations (PTOT-2.6).....	34
Swallowing and Feeding Considerations (PTOT-2.7).....	36
Vestibular Considerations (PTOT-2.8).....	38
References (PTOT)	40
References (PTOT).....	41

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

Guideline	Page
Clinical Review Criteria: Physical Therapy (PT) and Occupational Therapy (OT) Services (PTOT-1.0).....	4
Definitions (PTOT-1.1).....	5
Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care (PTOT-1.2).....	11
Rules, Coverage, Benefits, and Mandates (PTOT-1.3).....	18

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

PTOT.1.0.A

v1.0.2026

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 (therapy visits) 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 (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 may 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.

Definitions (PTOT-1.1)

PTOT.1.1.A

v1.0.2026

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.

Caregiver

For the entirety of this document, the terms "caregiver" or "caregivers" refers to any non-clinical caregivers or caretakers (including aides, caregivers, restorative staff, parents, guardians, family, friends, etc.) that may be assisting the individual. (See "Individual" below)

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, family member, 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 develop new skills or functions that are age appropriate and 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 This may also include periodic care to educate the individual on progressive debility or anticipated functional losses (i.e., planning for progressive losses due to degenerative conditions).

- **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 visits generally occur infrequently and should only be utilized to establish goals and steps of the program with the individual and caregiver. The actual program is intended to be carried out independently by the individual and their trained caregivers.²
- **Skilled rehabilitative care** are services aimed at restoring an individual's physical function or mobility that has been lost or impaired due to injury, illness, surgery, disability, or other medical conditions. These services focus on improving functional limitations related to the body's structure or movement while also addressing environmental or personal factors that may hinder recovery. The ultimate goal is to help the individual regain a level of physical ability sufficient to perform essential activities of daily living (ADLs) and instrumental activities of daily living (IADLs). 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 rehabilitative.²

Complexities / Complications

Individuals may present with any variety of health challenges not directly associated with the condition for which they are seeking care, that significantly impact their functional ability. 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 that involve 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)

Medically Necessary⁴

Healthcare services or supplies needed to diagnose, treat, or evaluate a condition or prevent an injury, illness, condition or disease that meet 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 abilities 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 Organization¹. 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, a higher severity rating does not always guarantee authorization of care, but rather authorizations should be based on all factors that support medical necessity.

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 Lower-level research (cohort studies, non-randomized studies, case studies, expert opinion) may be helpful in establishing a standard of practice if there is no higher-level research established. The section **PTOT-2.0: Clinical Considerations** in this publication provides additional context in reference to usual and reasonable care for common areas of practice within skilled therapy.

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

PTOT.1.2.A

v1.0.2026

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 using 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 for choosing 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 already provided with respect 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

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 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 function 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 the individual's discharge from the provider's care 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 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 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 and 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. Rather, 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 and may involve complexities and complications that further support the need for care. An individual's health plan policy and visit limitations will vary and must be followed. Current best evidence recommendations from healthcare research on the dosage of skilled visits should also be included in considerations when available and applicable. 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 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 the place of the medical necessity criteria 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 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 for practicing said programs consistently outside of clinical visits. Practice does not always need to be perfect or require extensive feedback. Decisions on the number of skilled care visits take into account that individuals need time between clinic visits to practice and adapt to their prescribed home program.

Severity – Individuals with higher levels of dysfunction (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/environmental factors may contribute to a higher severity of the functional problems. Severity levels provided 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 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. It is the responsibility of the provider to recognize when it is appropriate to decrease the frequency of visits during the course of an individual's post-operative care. 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 the most efficacious dosage of skilled therapy for an episode of care is minimal. Research is adequate to show that skilled care treatments can be effective at causing meaningful change. However, research is not adequate to show what number of visits is a superior dosage in most clinical situations. Published research and guidelines do provide recommended visit ranges for some conditions, however these ranges are often quite wide and vary by source which limits their utility in determining medical necessity. EviCore reviews current research and incorporates applicable evidence, in addition to considering all individual factors, when determining a certain 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 that 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 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.

Health Equity - Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Discontinuation of Skilled Care

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

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

PTOT.1.1.A**v1.0.2026**

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 (e.g., reconsideration and appeals) and points of contact for those next steps. It is the provider's responsibility to read determination letters.

Clinical Considerations (PTOT-2.0)

Guideline	Page
Clinical Considerations (PTOT-2.0).....	20
Integumentary Considerations (PTOT-2.1).....	22
Lymphatic Considerations (PTOT-2.2).....	25
Musculoskeletal Considerations (PTOT-2.3).....	27
Neurological Considerations (PTOT-2.4).....	29
Pediatric Neurodevelopmental Considerations (PTOT-2.5).....	32
Pelvic Considerations (PTOT-2.6).....	34
Swallowing and Feeding Considerations (PTOT-2.7).....	36
Vestibular Considerations (PTOT-2.8).....	38

Clinical Considerations (PTOT-2.0)

PTOT.2.0.A

v1.0.2026

EviCore takes into account current scientific evidence-based recommendations when evaluating a request for an appropriate need for skilled care visits. 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 visits. 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 therefore will be reviewed on a case by case basis. The individual's need for skilled care visits is evaluated and determined based on the individual's presentation, response to the plan of care, and their activity/participation level versus just on specific treatments/techniques. Just because a treatment or method has been shown to be effective in research does not mean it is medically needed in each case. However, recall that EviCore does not determine the specific therapy treatments or services a provider can use during a clinical visit (See PTOT-1.0). 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 for 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 provide a more comprehensive picture of the individual's clinical presentation. All pertinent

and applicable clinical information submitted documenting an individual's progress is considered during the review process.

Integumentary Considerations (PTOT-2.1)

PTOT.2.1.A

v1.0.2026

Wounds are typically defined as the disruption of integumentary integrity. They may be the result of pressure, impaired blood flow, neuropathy, trauma, surgical procedures, burns, anatomical deformities or systemic diseases. Wounds may be acute or chronic. Chronic lesions fail to progress through the normal stages of wound healing in a predictable, orderly and timely manner. Wounds are generally defined as being chronic after showing no significant progress toward healing in 30 days despite standard care treatment.¹⁴⁻¹⁵

Current peer-reviewed recommendations suggest initiating skilled care for chronic wounds that are refractory to healing or have complicated healing cycles. Consideration of the need for skilled care necessitates identifying the characteristics of the wound as well as potential causes of delayed wound healing. Standardized valid measures of wound characteristics are recommended to be used to demonstrate levels of abnormality. Baseline measures of wound dimensions, the presence (and extent of) necrotic or non-viable tissue, the presence (and quality of) exudate, the presence of obvious signs of infection and the presence of other abnormalities in the wound that may inhibit healing are expected to be assessed at the start of an episode of care. Standardized tools that measure the severity of tissue loss are also recommended to be used to demonstrate extent of abnormality [i.e. NPUAP Classification for Pressure Injury Staging, ABA Thermal Injury Classification]. Published peer reviewed clinical practice guidelines for wound management recommend the re-assessment of these measurements routinely throughout an episode of care.¹⁴⁻²⁰ The tracking of tissue health and changes over finite periods of time will help determine the need for continued skilled care.

Continuation of skilled services will be considered if there is documented evidence of the effectiveness of the services being provided. Evidence of improvement may include measurable changes in wound size, an increased presence of granulation tissue or the reduction of swelling, drainage, necrotic tissue/slough and inflammation. Scores from validated assessment tools, such as The Pressure Ulcer Scale for Healing (PUSH) and the Wagner Grading System, may also be suitable for assessing appropriate wound healing.^{17,21} Only when there is documented evidence of clear benefit from the services provided, should services be continued. Current peer-reviewed literature has advised that reasonable progress with wound healing should be evident within a 2-4 week period of time.^{15,20,22,23} 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.²⁴ If appropriate wound healing is not achieved during a 2 to 4 weeks period of time, current peer-reviewed recommendations indicate the treatment plan must be appropriately modified.^{14,16-20,25}

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.¹⁴⁻²⁰

Consideration of the need for continued skilled care additionally necessitates identifying the presence of any complications or complexities. Common localized wound complexities include infection, biofilm, necrotic tissue, hypergranulation, callous formation, undermining and tunneling. Common systemic complexities which may impede wound healing include metabolic, vascular and autoimmune disorders, nutritional deficits, orthopedic conditions, mobility impairments and contractures.^{14-20,23} Depending upon the nature and severity of the complexities present, all wounds may not have the potential to achieve full closure. Patient non-compliance with treatment plans may also halt healing and prevent full wound closure. Patient compliance issues may include off-loading limbs, redistributing weight, immobilizing joints, donning compression garments, diet compliance and smoking cessation.^{14-20,23} Vascular incompetence, development of musculoskeletal contractures or further tissue destruction may occur and require the need for surgical intervention.^{14,16-18,22,26} Severe burns may have received skin grafting or other surgical intervention. The effect that complexities and complications may have on the healing potential of a lesion will be considered on a case-by-case basis (see Complexities/Complications in **PTOT-1.1: Definitions**)

Recent research has supported the use of adjunctive therapies to accelerate wound healing. There is strong evidence to support the use of sharp debridement, electrical stimulation, pulsed lavage, ultrasound, negative pressure wound therapy (NPWT) and topical oxygen therapy to stimulate wound healing.^{15,16-19,21} Debridement of the wound(s), if indicated, is performed to actively and skillfully remove necrotic tissue and/or devitalized tissue to promote healing. The mere removal of secretions/crusts or cleansing of a wound, does not represent a skilled debridement service. Phototherapy (UVA, UVB, UVC) can be an effective treatment for skin conditions such as eczema, psoriasis and vitiligo.²⁷⁻²⁹

Recent wound care guidelines have supported the eventual transition of care to the individual via a home management program. Education regarding self-management should include patient-specific strategies. Self-management may consist of wound cleansing, dressing changes, application of topical medications, compression, contracture management, pressure redistribution or therapeutic exercises.^{14,15,17} The transfer of care to the individual is expected once the wound reaches a state

at which its care can be performed primarily by the individual and/or caregiver with periodic provider assessment and supervision. Such states may include, but is not limited to, a wound bed being covered with 100% granulation tissue, a wound having achieved full closure or a wound achieving a stable status. The transfer of care to a home maintenance program may also be indicated for wounds that are not responsive to care.^{14,15,18,20,22,,23,26}

Lymphatic Considerations (PTOT-2.2)

PTOT.2.2.A

v1.0.2026

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 to perform ADLs/IADLs due to restricted joint and tissue mobility and the added weight to the affected areas. The accumulation of fluid in the affected area may negatively impact the health and function of other body systems 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 thus, varying 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.³⁰ 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.³¹ 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. Despite this, 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.³²

An individual may be seeking skilled care for lymphedema, or other sequelae (e.g., axillary web syndrome) that are the result of surgeries or procedures related to the treatment of cancer and other pathologies. Techniques and approaches for these procedures will vary greatly. Individuals will have varied healing responses. 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 management demonstrate that skilled care can reduce edema and that individuals can be transitioned to a self-maintenance program to be used over time. Current treatment recommendations correlate with the stage of lymphedema an individual would be classified in at a given time.^{30,31} The less severe stages may only

require self-care, occasional monitoring, elevation and/or compressive garments.^{31,33} As edema progresses in severity, an episode of skilled care for complete decongestive therapy (CDT) may be indicated.³⁰⁻³⁵ 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. Recent evidence also demonstrates that short term manual lymphatic drainage techniques can be effective in reducing axillary web symptoms (pain, range of motion, self-rated ability) aside from edema reduction alone.^{36,37}

Musculoskeletal Considerations (PTOT-2.3)

PTOT.2.3.A
v1.0.2026

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 skilled care for an individual with an MSK problem 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.³⁸⁻⁷⁴ Strong recommendations support that services should be customized to the individual.^{43-45,47-51,53,56-73} 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.^{38-51,53-68} Establishing a plan for independent long-term self-care and exercise is highly recommended for individuals with chronic conditions.^{41,44,50,53,58,60,63,69-73} 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.⁴³⁻⁷³ Recommendations on the regular use of passive techniques and physical agents as stand-alone treatments are limited. Passive treatments may have some short-term utility in improving pain related disability when appropriately combined as adjuncts to a comprehensive therapy plan of care.³⁸⁻⁷⁴

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 post surgery. Surgical approaches and techniques will vary. Individuals may respond differently to certain procedures. 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.^{38-46,48,51,52,54-56,67,68,71}

Neurological Considerations (PTOT-2.4)

PTOT.2.4.A**v1.0.2026**

Neurological conditions are typically characterized by limitations with ADLs/IADLs, such as mobility, strength, coordination and balance, 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**). An 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 neurological diseases) 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. Realistic prognosis determination is an important consideration with each individual; how much an individual is expected to improve, plateau or decline will be a factor in determining the need for skilled care. The neurological presentation of an individual may reduce the ability of a provider to obtain reliable assessment scores. These situations and circumstances should be clearly documented. All efforts will be made during the review process to consider submitted scores/measures within the clinical situation of each individual.

Individuals with neurological conditions may be classified into severity groups 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

appropriate treatment approaches. This clinical information may provide added 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 diseases. 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.⁷⁵⁻⁹¹ The literature recommends that skilled care should focus primarily on active motor strategies and patient/caregiver education; the education provided should address the individual's specific disabilities with an ultimate goal of empowering the individual to effectively transition to a home program. Strong recommendations have been made that caregivers be involved during all stages of an episode of care.⁷⁵⁻⁹¹ There is strong evidence supporting the benefit of targeted exercise and training on mobility problems.⁷⁵⁻⁹¹ In recent years, increasing emphasis has been placed on the importance of a greater intensity of activity to be performed in treatment, compared to previously. If the exercise prescription is not challenging or is routine, it may not drive positive change.^{76,78,81,82,84,87,88} Recommendations for the use of passive treatments and techniques to improve function during neurological rehabilitation are very limited. Evidence suggesting the necessity of the regular use of body-weight support training, robotic/exoskeleton support training, and vibration plates is inconclusive.^{81,84,87} Individuals can learn a home program with their caregivers and repeat their program on their own (or with their caregiver) between in-clinic sessions. It is also recommended that individuals and their caregivers be informed and educated on the reality of their neurological condition and be given realistic goals and expectations.⁷⁵⁻⁹¹

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.^{89,90}

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, including the use of caregivers is recommended.^{76,78,79,83,85,91}

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 sessions should be moderate to high in intensity requiring sufficient effort from the individual.^{83,92,93}

Pediatric Neurodevelopmental Considerations (PTOT-2.5)

PTOT.2.5.A

v1.0.2026

Neurodevelopmental conditions disrupt typical growth and development, usually characterized by abnormal motor and sensory skills which may present 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.⁹²⁻⁹⁴ Baseline standardized testing of milestone attainment and deficits in essential tasks should be assessed at the initiation of an episode of care.⁹²⁻⁹⁴ 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 should be provided. Appropriate measures should be used at regular intervals to track the response to the care being provided (**PTOT-2.0: Clinical Considerations**). In special cases or particular situations where these measures cannot be obtained, 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.⁹²⁻⁹⁴ Complexities and complications may arise due to other medical procedures, surgeries or medication changes.⁹⁵ 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. It is important to determine a reasonable prognosis in every case so that realistic goals may be developed for each patient in an episode of care.

Current peer-reviewed guidelines recommend skilled care for individuals presenting with pediatric neurodevelopmental conditions should be task-oriented.⁹²⁻⁹⁸ 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].⁹²⁻⁹⁸ 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.^{92,94,96,98} In addition, there are strong recommendations for parents/caregivers to be taught appropriate play and developmental activity strategies through coaching and education.^{93,94,97,98} 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.^{94,97} For children and young people who are considered to have a severe motor impairment, there is not much evidence supporting the benefit of therapy 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.⁹⁶ Adaptive equipment and assistive technology may be beneficial.

Pelvic Considerations (PTOT-2.6)

PTOT.2.6.A

v1.0.2026

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 of presentation and severity. 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. Administering standardized, valid, functional outcome- and performance-based measures is recommended to demonstrate the individual's level of dysfunction. The functional outcome measures should be administered to the patient periodically throughout the episode of care to assess progress and/or to determine whether an individual is responding appropriately to the plan of care (See **PTOT-2.0: Clinical Considerations**).¹⁰⁰⁻¹⁰⁴ 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, specific triggers of symptoms, or to track frequency of applicable incidents of a specified dysfunction. Measuring performance over time can be a useful tool in tracking response to care and progress. Whenever possible, valid standard measures should be used in conjunction with 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 techniques will vary. Individuals may have different responses to certain procedures. 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.^{101,102,104,105}

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. In each particular case, an individual's current functional deficits and all pertinent clinical information will be assessed to determine the need for skilled care (See **PTOT-1.2: Criteria to Determine Medical Necessity for Skilled Physical/Occupational Therapy Care**).

Recent published guidelines and reviews provide recommendations of reasonable skilled care for pelvic dysfunctions.¹⁰⁰⁻¹⁰⁶ Strong recommendations have been made that skilled services be customized to the individual and include active strategies such as pelvic floor muscle training and educating the patient to increase physical activity as first-line skilled care options.¹⁰⁰⁻¹⁰⁶ Familiarity with current exercise recommendations and contraindications for individuals during the antepartum period is strongly supported.^{101,102,104,105} It is recommended that individuals be empowered to complete a regular home program that is tailored to their needs. Home programs incorporate active treatments into daily life.¹⁰⁰⁻¹⁰⁶ Use of manual therapy techniques may be beneficial as a short-term adjunct to facilitate active strategies.¹⁰⁰⁻¹⁰⁴ 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.^{102,103,105,106} Passive treatment during acute stages may lead to better tolerance of active care in future sessions, but it should not be used throughout the entire course of care.¹⁰⁰⁻¹⁰⁴

Swallowing and Feeding Considerations (PTOT-2.7)

PTOT.2.7.A

v1.0.2026

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 the care being provided (See **PTOT-2.0: Clinical Considerations**).^{93,94,107,108} 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 and the individual should be transitioned to a home program as soon as possible.^{93,94,107-110} 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.¹⁰⁷⁻¹¹⁰ Neurostimulation therapies, such as transcranial magnetic stimulation, can be effective for post-stroke dysphagia.¹¹¹ Positioning modifications can improve swallowing.⁹³⁻⁹⁵ 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.^{94,112-117} It has been recommended that individuals weaning from tube feeding can benefit from hunger provocation and behavioral programs.¹¹⁷ Skilled care for swallowing and feeding should focus on empowering an individual and their caregiver to become independent once a home program is established.

Vestibular Considerations (PTOT-2.8)

PTOT.2.8.A

v1.0.2026

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 severe symptoms that 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.¹¹⁸⁻¹²² 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 should be used to demonstrate levels of deficit. These assessments are recommended to be administered periodically throughout the course of care to assess progress and that the individual is responding appropriately to the plan 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.¹¹⁸⁻¹²² It is recommended that usual care for BPPV includes procedures for canalith repositioning. It is recommended that skilled care for vestibular hypofunction and dizziness includes 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.¹²² 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 a focus on transitioning the patient 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.¹¹⁸⁻¹²²

References (PTOT)

Guideline	Page
References (PTOT).....	41

References (PTOT)

v1.0.2026

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