**Policy:** **Medical Necessity Decision Assist Guideline for Rehabilitative Care**

**Date of Implementation:** **February 5, 2004**

**Product:** **Specialty**

Related Policies:
CPG 1: X-Ray guidelines
CPG 110: Medical Record Maintenance and Documentation Practices
CPG 111: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations
CPG 121: Passive Physiotherapy Modalities
CPG 129: Electrodiagnostic Testing
CPG 135: Physical Therapy Medical Policy/Guideline
CPG 155: Occupational Therapy Medical Policy/Guideline
CPG 167: Therapeutic Massage Medical Policy/Guideline
CPG 169: Psychosocial Factors in Pain Management
CPG 264: Acupuncture Services Medical Policy/Guideline
CPG 278: Chiropractic Services Medical Policy/Guideline

Medical necessity evaluations require approaching the clinical data and scientific evidence from a global perspective and synthesizing the various elements into a congruent picture. This American Specialty Health – Specialty (ASH) Clinical Practice Guideline (CPG) provides a comprehensive overview of ASH Medical Necessity Decision Assist Guidelines for the following:

- Verifying those services submitted meet the definition of Medical Necessity;
- Denial of coverage of services submitted for failing to meet the definition of Medical Necessity; and
- Identifying cases in which submitted documentation suggests the need for referral or coordination of care.

**Please note:** Client exceptions to ASH clinical practice guidelines can be provided by contacting the Customer Service Department at 800-678-9133.

## DEFINITIONS OF KEY TERMINOLOGY

***Medical Necessity***



**CPG 12 Revision 29– S**
Medical Necessity Decision Assist Guideline for Rehabilitative Care
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ASH clinical quality evaluators evaluate medical necessity of services consistent with the definition of medical necessity adopted by the Quality Oversight Committee as reflected in the *Medical Necessity Definition (UM 8* – S) policy.

***Musculoskeletal Conditions***
Illness, injury, or disease involving the connective and/or contractile tissues of the body, including bone, joint, ligament, muscle, tendon and fascia.

***Neurologic/Neuromuscular Conditions***
Neurological disorders are diseases of the brain, spine and the nerves that connect them. These disorders can also occur with musculoskeletal conditions and are referred to as neuromuscular conditions (e.g., radiculopathy).

***Cardiopulmonary Conditions***
Cardiopulmonary disease generally refers to conditions that involve the heart, lungs and associated major vessels.

***Integumentary Conditions***
Integumentary conditions generally involve wounds and other conditions of the skin that are amenable to skilled care to promote healing.

***Other Conditions***
Other conditions amenable to rehabilitation not included within the conditions defined above.

***Elective/Convenience Services***
Examples of elective/convenience services include: (a) preventive services; (b) wellness services; (c) services not necessary to return the patient to pre-illness/pre-injury functional status and level of activity; (d) services provided after the patient has reached Maximum Therapeutic Benefit. Elective/convenience services may not be covered through ASH benefits; see the *Medical Necessity Definition (UM 8 – S)* policy.

***Chiropractic Maintenance Therapy Services***
Chiropractic maintenance therapy services are defined as a treatment plan that seeks to prevent disease, promote health, correct subluxations unrelated to a diagnosed illness or injury, and prolong and enhance the quality of life and is not directed toward a specific condition that is expected to improve or resolve in a reasonable period of time (corrective care). Medicare also includes supportive care as maintenance care and considers all forms of chiropractic maintenance care as not covered. (See definition of *Chiropractic Supportive Care below.)* (Chiropractic maintenance therapy services are not generally covered under Commercial benefits.)

***Chiropractic Supportive Care Services***

Supportive care is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain this benefit and progressively deteriorate when there are periodic withdrawals of treatment. Supportive care follows appropriate application of passive and active care including rehabilitation and lifestyle modifications. Supportive care cannot be scheduled and should be rendered on an "as needed" basis (PRN) for up to 4 months in duration. Detailed and adequate documentation of each aspect and phase of intervention and patient's response to care is necessary to document the medical necessity of Supportive Care. Supportive care is not a covered benefit under Medicare but may be covered under some Commercial benefits. Medicare defines supportive care as: *when further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.*

***Preventive Services***

Preventive services are designed to reduce the incidence or prevalence of illness, impairment, and risk factors, and to promote optimal health, wellness, and function. These services are not designed or performed to treat or manage a specific health condition. (*Preventive services* may not be covered under specific clients or through ASH benefits.)

***Rehabilitative Services***

Rehabilitative services are intended to improve, adapt, or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time (2- 8 weeks).

***Habilitative Services***

Habilitative services are intended to maintain, develop, or improve skills needed to perform Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality. Habilitative services are not addressed in this guideline; refer to *Physical Therapy (CPG 135 – S), Occupational Therapy (CPG 155 – S), Speech Language Pathology/Speech Therapy (CPG 166 - S), and Chiropractic Services (CPG 278 - S) Medical Policy/Guidelines* for more information.

***Skilled Maintenance Therapy Services***

Skilled maintenance therapy services are where individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified physical or occupational therapist or speech language pathologist are necessary to maintain the patient's current condition or to prevent or slow further deterioration. Such a maintenance program must demonstrate the need for a skilled professional to ensure the

services are safe and effective to improve, maintain or slow deterioration of a patient's condition. Maintenance care may involve periodic withdrawals of treatment, decreased frequency of care, and/or periodic follow up with the skilled professional to reassess the patient's condition and to update and/or modify the treatment plan.

***Minimal Clinically Important Difference***

The Minimal Clinically Important Difference (MCID) is the minimal amount of change in a score of a valid outcome assessment tool that should be considered to indicate an actual improvement in the patient's function or pain. This is a statistical number which has been validated and is reproducible with the scale. However, MCIDs are variable by tool depending upon the patient population studied.

***Maximum Therapeutic Benefit***

Maximum Therapeutic Benefit (MTB) is the patient's health status when the application of skilled therapeutic services has achieved its full potential. Continuation of the same skilled treatment approach will not significantly improve the patient's impairments and function during this episode of care.

If the patient continues to have significant complaints, impairments, and documented functional limitations, one should consider the following:

- Altering the treatment regimen. Such as, utilizing a different physiological approach to the treatment of the condition or withdrawal of predominately passive care (modalities, massage, etc.) and increase the active care (therapeutic exercise) aspects of treatment to attain greater functional gains;
- Reviewing self-management program including home exercise programs; and/or
- Referring the patient for consultation by another health care practitioner for possible co-management or a different therapeutic approach.

***Acute***

The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is less than six weeks in duration, typically characterized by the presence of one or more signs of inflammation or other adaptive response.

***Sub-Acute***

The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is greater than six weeks, but not greater than twelve weeks in duration.

***Chronic***

The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is greater than twelve weeks in duration.

***Red Flag(s)***

Signs and symptoms presented through history or examination/assessment that warrant more detailed and immediate medical assessment and/or intervention.

***Yellow Flag(s)***
Adverse prognostic indicators with a psychosocial predominance associated with chronic pain and disability. Yellow flags signal the potential need for more intensive and complex treatment and/or earlier specialist referral.

***Co-Morbid Condition(s)***
The presence of a concomitant condition, that has an unrelated pathology or disease process, but may inhibit, lengthen, or alter in some way the expected response to care.

## FACTORS INFLUENCING CLINICAL SERVICE APPROVALS

- No evidence of contraindication(s) to services submitted for review;
- Complaints, exam findings, and diagnoses correlate with each other;
- Treatment Plan is supported by the nature and severity of complaints;
- Treatment Plan is supported by exam findings;
- Treatment Plan is expected to improve symptoms (e.g., pain, function) within a reasonable period of time;
- Maximum therapeutic benefit has not been reached;
- Treatment Plan requires the skills of the provider; and
- Demonstration of progression toward active home/self- care and discharge.

**Patient History/Complaint with Clinical Findings**
Stage of Condition – acute, subacute, or chronic

- Documentation noted of rapid, insidious, or traumatic onset, exacerbation, or recurring with duration of symptoms
- Severity of symptoms
- Report of functional deficits and ADL restrictions if present, with appropriate functional outcome measure (FOM)
- Absence of red or yellow flags noted
- If applicable, prior similar treatment has been successful

Coherence between history, exam/evaluation findings, diagnosis, and documented plan of care

- Diagnosis supported via subjective and objective findings that are clearly defined and quantified
- Approve the level of services necessary for pain/symptom relief and functional improvement as indicated by all submitted pertinent clinical evidence, such as:
    - Severity of various historical and exam findings
    - Inclusion of active care and reduction of passive care
    - Condition amenable to treatment plan of care

  - The member has made reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services
  - Additional significant improvement can be reasonably expected by continued treatment
  - The member has not reached maximum therapeutic benefit (MTB) per previous definition
- Confirm appropriate coordination of other appropriate health care services, if necessary

If treatment has been provided, improvement reported (but not to pre-clinical status) and documentation of the following items to support continuation of services including but not limited to (based on diagnosis):

- Pain improved significantly
- Frequency of symptoms substantially decreased (e.g., decreased tenderness, muscle spasm)
- Functional deficits or impairments absent or significantly improved as compared to baseline
- ROM and muscle strength improving
- Special test findings reduced or negative
- Increased ability to do ADLs
- Improved orthopedic and/or neurological findings (e.g., balance, proprioception)
- Centralization of referred and/or radiating pain if symptoms were originally present
- Member complying with treatment plan (e.g., willingness to make necessary lifestyle changes to help reduce frequency and intensity of symptoms)
- No signs that the need for additional services is due to new complicating factors or misdiagnosis

For cases justifying the need for supportive or skilled maintenance care:

- Approve the level of services that has previously shown to be effective in reducing, maintaining, or alleviating the member's pain/symptoms.
- The risk of treatment dependency should always be considered.

Other considerations:

- Clinical quality evaluators are trained to identify variations in clinical presentation that may influence the approval of a treatment plan.
- The use of passive physiotherapy modalities in the treatment of sub-acute or chronic conditions beyond the acute inflammatory response time frame requires documentation of

the anticipated benefit and condition-specific rationale in order to be considered medically necessary.

- Use of multiple passive physiotherapy modalities with similar physiologic effects to the same region should be considered a duplication of services and not medically necessary.
- The use of passive physiotherapy modalities as stand-alone treatments is rarely therapeutic, and thus not required or indicated as the sole treatment approach to a patient's condition.
- Uncomplicated diagnoses do not typically require services beyond the initial treatment plan before discharging patient to active home/self-care.
- Frequency of services generally decreases as symptoms and clinical findings improve.

Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary, even if they are performed or supervised by a practitioner. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.

## FACTORS INFLUENCING DETERMINATIONS OF MEDICAL NECESSITY (PARTIAL APPROVALS/DENIALS)

- Lack of documentation to support the diagnosis;
- Documentation insufficient to reliably verify the nature of the patient's clinical health status and response to care, such as outdated and/or not clearly defined or quantified findings, including but not limited to: objective and subjective information, functional outcome measures, tests and measures, etc.;
- Complaints and symptoms are not clearly described;
- Treatment/therapy is inappropriate or unrelated to the condition/diagnosis;
- Discrepancy between complaints and/or description of severity and/or evaluation findings as documented by practitioner and member;
- Inaccurate reporting of clinical findings;
- Therapeutic goals have not been documented (Goals should be written in terms of function and include specific parameters with objective statements of a goal that make it measurable and ensure that anyone who reads the goals will have a clear picture of what outcome is expected, including timeframes, distance, level of assistance, specific functional activity, etc.);
- There is prolonged reliance on passive care which is not supported by the clinical literature;
- Home care, self-care, and active-care instructions are not documented;

- Identification of absolute or relative contraindications to care (co-morbid conditions or red flags such as, history of stroke or transient ischemic attacks [TIAs], progressive spondylolisthesis, uncontrolled hypertension, inflammatory arthritis, joint hypermobility, bone tumors, osteopenia/osteoporosis, bleeding disorders or anticoagulant therapy);
- Signs, symptoms and/or other pertinent information presented through history and/or physical examination and/or response to care requiring urgent attention, further testing, and/or possible specialist referral;
- Signs, symptoms and/or other pertinent information presented through history and/or physical examination that requires a referral to another health care practitioner for co-management and/or practitioner refuses to refer;
- Initial treatment has not demonstrated significant clinical improvement;
- Preventive services, chiropractic maintenance therapy service or elective/convenience services;
- Case requires referral to the referring or appropriate physician or other health care practitioner;
- Clinically significant therapeutic progress (MCID, improvement in pain, impairments, and objective evaluation findings) is not evident through assessment of the records submitted, indicating Maximum Therapeutic Benefit has been reached;
- Patient has returned to pre-clinical status or has been unresponsive to care; and
- Evidence of treatment dependency and/or presence of Yellow Flags;
- Services do not require the necessity of a skilled rehabilitative practitioner.

For specialty specific factors that may influence adverse determinations of Clinical Services (Partial Approvals/Denials), refer to the applicable specialty specific ASH Clinical Practice Guideline(s) (e.g., Acupuncture, Chiropractic, Physical Therapy, Occupational Therapy).

## ADDITIONAL FACTORS CONSIDERED IN DETERMINATION OF MEDICAL NECESSITY – PARTIAL APPROVAL/DENIAL

### History / Complaints / Patient Reported Outcome Measures

- The patient's complaint(s) and/or symptom(s) are not clearly described.
- There is poor correlation and/or a significant discrepancy between the complaint(s) and/or symptom(s) as documented by the treating practitioner and as described by the patient.
- The patient's complaint(s) and/or symptom(s) have not demonstrated clinically significant improvement.
- The nature and severity of the patient's complaint(s) and/or symptom(s) are insufficient to substantiate the medical necessity of any/all submitted services.

- The patient has little, or no pain as measured on a valid pain scale.
- The patient has little, or no functional deficits using a valid functional outcome measure or as otherwise documented by the practitioner.

**Evaluation Findings**

- There is poor correlation and/or a significant discrepancy in any of the following:
  - Patient's history
  - Subjective complaints
  - Objective findings
  - Diagnosis
  - Treatment plan
- The application of various exam findings to diagnostic or treatment decisions are not clearly described or measured. (e.g., severity, intensity, professional interpretation of results, significance).
- The patient's objective findings have not demonstrated clinically significant improvement.
- The objective findings are essentially normal or are insufficient to support the medical necessity of any/all submitted services.
- The submitted objective findings are insufficient due to any of, but not limited to, the following reasons:
  - Old or outdated relative to the requested dates of service
  - Do not properly describe the patient's current status
  - Do not substantiate the medical necessity of the current treatment plan do not support the patient's diagnosis/diagnoses do not correlate with the patient's subjective complaint(s) and/or symptom(s)
- Not all of the patient's presenting complaints were properly examined.
- The patient does not have any demonstrable functional deficits or impairments.
- The patient has not made reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services.
- Clinically significant therapeutic progress is not evident through a review of the submitted records. This may indicate that the patient has reached maximum therapeutic benefit.
- The patient is approaching or has reached maximum therapeutic benefit.
- The patient's exam findings have returned to pre-injury status or prior level of function.
- There is inaccurate reporting of the patient's clinical findings.
- The exam performed is for any of the following:
  - Wellness
  - Pre-employment
  - Sports pre-participation
- The exam performed is non-standard and solely technique/protocol based.

- The procedure(s) used to validate subluxation(s) are considered not-evidence based, not widely accepted, and/or not reasonable or medically necessary (e.g., Functional leg length assessment, surface electromyographic study).

**Diagnosis**

- The diagnosis is not supported by one or more of the following:
  - Patient's history (e.g., date/mechanism of onset)
  - Subjective complaints (e.g., nature and severity, location)
  - Objective findings (e.g., not clearly defined and/or quantified, not professionally interpreted, significance not noted)

**Submitted Medical Records**

- The submitted records are insufficient to reliably verify pertinent clinical information, such as (but not limited to):
  - Patient's clinical health status
  - The nature and severity of the patient's complaint(s) and/or symptom(s)
  - Date/mechanism of onset
  - Objective findings
  - Diagnosis/diagnoses
  - Response to care
  - Functional deficits/limitations
- There are daily notes submitted for the same dates of service with different/altered findings without an explanation.
- There is evidence of duplicated or nearly duplicated records for the same patient for different dates of service, or for different patients.
- There is poor correlation and/or a significant discrepancy between the information presented in the submitted records with the information presented during a verbal communication between the reviewing CQE and treating practitioner.
- The treatment time (in minutes) and/or the number of units used in the performance of a timed service (e.g., modality, procedure) during each encounter/office visit was not documented.
- Some or all of the service(s) submitted for review are not documented as having been performed in the daily treatment notes.

**Treatment / Treatment Planning**

- The submitted records show that the nature and severity of the patient's complaint(s) and/or symptom(s) require a limited, short trial of care in order to monitor the patient's response to care and determine the efficacy of the current treatment plan. This may include, but not limited to, any of the following:
  - Significant trauma affecting function
  - Acute/sub-acute stage of condition
  - Moderate-to-severe or severe subjective and objective findings

  - Possible neurological involvement
  - Presence of co-morbidities that may significantly affect the treatment plan and/or the patient's response to care
- There is poor correlation of the treatment plan with the nature and severity of the patient's complaint(s) and/or symptom(s), such as (but not limited to):
  - Use of acute care protocols for chronic condition(s)
  - Prolonged reliance on passive care
  - Active care and reduction of passive care are not included in the treatment plan
  - Use of passive modalities in the treatment of sub-acute or chronic conditions beyond the acute, inflammatory response time frame
  - Use of passive modalities as stand-alone treatments (which is rarely therapeutic) or as the sole treatment approach to the patient's condition(s)
- There is evidence from the submitted records that the patient's treatment can proceed safely and effectively through a home exercise program or self-management program.
- The patient's function has improved, complaints and symptoms have decreased, and patient requires less treatment (e.g., lesser units of services per office visit, lesser frequency, shorter total duration to discharge).
- The patient's symptoms and/or exam findings are mild and the patient's treatment plan requires a lesser frequency (e.g., units of services, office visits per week) and/or total duration.
- Therapeutic goals have not been documented. Goals should be measurable and written in terms of function and include specific parameters.
- Therapeutic goals have not been reassessed in a timely manner to determine if the patient is making expected progress.
- Failure to make progress or respond to care as documented within subjective complaints, objective findings and/or functional outcome measures.
- The patient's condition(s) is/are not amenable to the proposed treatment plan.
- Additional significant improvement cannot be reasonably expected by continued treatment and treatment must be changed or discontinued.
- The patient has had ongoing care without any documented lasting therapeutic benefits.
- The condition requires an appropriate referral and/or coordination with other appropriate health care services.
- The patient is not complying with the treatment plan that includes lifestyle changes to help reduce frequency and intensity of symptoms.
- The patient is not adhering to treatment plan that includes medically necessary frequency and intensity of services.

- The use of multiple passive modalities with the same or similar physiologic effects to the identical region is considered a duplication of services and not reasonable or medically necessary.
- Home care, self-care, and active-care instructions are not implemented or documented in the submitted records.
- Uncomplicated diagnoses do not require services beyond the initial treatment plan before discharging the patient to active home/self-care.
- As symptoms and clinical findings improve the frequency of services (e.g., visits per week/month) did not decrease.
- The submitted services do not or no longer require the professional skills of the treating practitioner.
- The treatment plan is for any of the following:
  - Maintenance therapy (excluding other covered skilled maintenance therapy benefits)
  - Preventive care
  - Elective/convenience/wellness care
  - Back school
  - Group therapy (not one-on-one)
  - Vocational rehabilitation or return to work programs
  - Work hardening programs
  - Routine educational, training, conditioning, return to sport, or fitness.
  - Non-covered condition
- There is duplication of services with other healthcare practitioners/specialties.
- The treatment plan is not supported due to, but not limited to, any of the following reasons:
  - Technique-/protocol-based instead of individualized and evidence based
  - Generic and not individualized for the patient's specific needs
  - Does not correlate with the set therapeutic goals
  - Not supported in the clinical literature (e.g., proprietary, unproven)
  - Not considered evidence-based and/or professionally accepted
- The treatment plan includes services that are considered not evidence-based, not widely accepted, unproven and/or not reasonable or medically necessary, or inappropriate or unrelated to the patient's complaint(s) and/or diagnosis/diagnoses. (e.g., Low level laser therapy, axial/spinal decompression, select forms of EMS such as microcurrent, H-wave. Also see the *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133 – S*) clinical practice guideline for complete list).

## Health and Safety

- There are signs, symptoms and/or other pertinent information presented through the patient's history, exam findings, and/or response to care that require urgent attention, further testing, and/or referral to and/or coordination with other healthcare practitioners/specialists.
- There is evidence of the presence of Yellow and/or Red Flags. (See section on Red and Yellow Flags below.)
- There are historical, subjective, and/or objective findings which present as contraindications for the plan of care.

## ADDITIONAL CLINICAL REVIEW FACTORS CRITICAL FOR VERIFYING MEDICAL NECESSITY

### Identification of Complicating Factors/Barriers to Recovery

The complexity and/or severity of historical factors, symptoms, examination findings, and functional deficits play an essential role to help quantify the patient's clinical status and assess the effectiveness of planned interventions over time. CQEs consider patient-specific variables as part of the medical necessity verification process. The entire clinical picture must be taken into consideration with each case evaluated based upon unique patient and condition characteristics.

Such variables may include, but not be limited to co-morbid conditions and other barriers to recovery, the stage(s) of the condition(s), mechanism of injury, severity of the symptoms, functional deficits, and exam findings, as well as social and psychological status of the patient and the available support systems for self-care. In addition, the patient's age, symptom severity, and the extent of positive clinical findings may influence duration, intensity, and frequency of services approved as medically necessary. For example:

- Severe symptomatology, exam findings, and/or functional deficits may require more care overall (e.g., longer duration, more services per encounter than the average); these patients may require a higher frequency of care; but may require short-term trials of care initially to assess the patient response to care.
- Less severe symptomatology, exam findings and/or functional deficits usually require less care overall (e.g., shorter duration, fewer services per encounter, and frequency of encounters than the average); but may allow for less oversight and a longer initial trial of care.
- As patients age, they may have a slower response to care, and this may affect the approval of a trial of care.
- Because pediatric patients (under the age of 12) have not reached musculoskeletal maturity, it may be necessary to modify the types of therapies approved as well as shorten the initial trial of care.

- Complicating and/or co-morbid condition factors vary depending upon individual patient characteristics, the nature of the condition/complaints, historical and examination elements, and may require appropriate coordination of care and/or more timely re-evaluation.

The following are examples of potential complicating factors to consider for rehabilitative care of musculoskeletal conditions and pain disorders.

## General Factors

Multiple patient-specific historical and clinical findings may influence clinical decisions, such as but not limited to:

- Red flags - see below
- Psychosocial factors (yellow flags) – see below
- Co-morbid conditions (e.g., diabetes, inflammatory conditions, joint instability)
- Age (older or younger)
- Non-compliance with treatment and/or self-care recommendations
- Lack of response to appropriate care
- Lifestyle factors (e.g., smoking, diet, stress, deconditioning)
- Work and recreational activities
- Pre-operative/post-operative care
- Medication use (type and compliance)

## Nature of Complaint(s)

- Acute and severe symptoms
- Functional testing results that display severe disability/dysfunction
- Pain that radiates below the knee or elbow (for spinal conditions)

## History

- Trauma resulting in significant injury or functional deficits
- Pre-existing pathologies/surgery(ies)
- Congenital anomalies (e.g., severe scoliosis)
- Recurring exacerbations
- Prior episodes (e.g., >3 for spinal conditions)
- Multiple new conditions which introduce concerns regarding the cause of these conditions

## Examination

- Severe signs/findings
- Results from diagnostic testing likely to impact coordination of care and response to care (e.g., fracture, joint instability, neurological deficits)

## Assessment of Red Flags

At any time, the patient is under care, the practitioner is responsible for seeking and recognizing signs and symptoms that require additional diagnostics, treatment/service, and/or referral. A careful and adequately comprehensive history and evaluation in addition to ongoing monitoring during the course of treatment is necessary to discover potential serious underlying conditions that may need urgent attention. Red flags can present themselves at several points during the patient encounter and can appear in many different forms. If a red flag is identified during a medical necessity review, the CQE should communicate with the provider of services as soon as possible by telephone and/or through standardized communication methods. When a red flag is identified, the CQE may not approve services and recommend returning the patient back to the referring healthcare practitioner or referring the patient to other appropriate health care practitioner/specialist with the measure of urgency as warranted by the history and clinical findings.

Due to the rarity of actual red flag diagnoses in clinical practice, it is emphasized that the practitioner does not need to perform expensive or invasive diagnostic procedures (e.g., x-ray, advanced imaging, laboratory studies) in the absence of suspicious clinical characteristics. As an example, there is no need to screen the patient for red flag conditions by taking x-rays of the lower back if the initial presentation emerges as simple mechanical low back pain absent of red flag characteristics. Important red flags and events as well as the points during the clinical encounter at which they are likely to appear include but may not be limited to:

### Past or Current History

- Personal or family history of cancer;
- Current or recent urinary tract, respiratory tract, or other infection;
- Anticoagulant therapy or blood clotting disorder;
- Metabolic bone disorder (osteopenia and osteoporosis);
- Unintended weight loss;
- Unexplained dizziness or hearing loss;
- Trauma with skin penetration; and
- Immunosuppression (AIDS/ARC).

### Present Complaint

- Writhing or cramping pain;
- Precipitation by significant trauma;
- Pain worse at night or not relieved by any position;
- Suspicion of cerebrovascular compromise; and
- Symptoms indicative of progressive neurological disorder.

**Physical Examination/Assessment**

- Inability to reproduce symptoms of musculoskeletal diagnosis or complaints;
- Pulsing abdominal mass;
- Fever, chills, or sweats without other obvious source;
- New or recent neurologic deficit (special senses, sensory, language, and motor);
- Signs of carotid/vertebrobasilar insufficiency.
- Uncontrolled hypertension;
- Signs of nutritional deficiency;
- Signs of allergic reaction requiring immediate attention;
- Abuse/neglect; and
- Psychological distress.

**Pattern of Symptoms Not Consistent with Benign Disorder**

- Chest tightness, difficulty breathing, chest pain;
- Headache of morbid proportion;
- Rapidly progressive neurological deficit;
- Significant, unexplained extremity weakness or clumsiness;
- Change in bladder or bowel function;
- New or worsening numbness or paresthesia;
- Saddle anesthesia;
- New or recent bilateral radiculopathy.

**Lack of Response to Appropriate Care**

- History of consultation/care from a series of practitioners or a variety of health care approaches without resolving the patient's complaint;
- Unsatisfactory clinical progress, especially when compared to apparently similar cases or natural progression of the condition; and
- Signs and symptoms that do not fit the normal pattern and are not resolving.

**Assessment of Yellow Flags** [Refer to the *Psychosocial Factors in Pain Management (CPG 169 - S)* clinical practice guideline for detailed information]

When yellow flags are present, clinicians need to be vigilant for deviations from the normal course of illness. Examples of yellow flags include depressive symptoms, injuries still in litigation, signs, and symptoms not consistent with pain severity, and behaviors incongruent with underlying anatomic and physiologic principles.

If a yellow flag is identified during a medical necessity review, the reviewer should communicate with the provider of services as soon as possible by telephone and/or through standardized communication methods.

CQE may recommend returning the patient back to the referring healthcare practitioner or referring the patient to other health care practitioner/specialist as appropriate.

**Precautions and Contraindications to Therapeutic Modalities and Procedures**

1 The use of thermotherapy is contraindicated for the following:

- Recent or potential hemorrhage
- Thrombophlebitis
- Impaired sensation
- Impaired mentation
- Malignant tumor
- IR irradiation of the eyes

Precautions for use of thermotherapy include:

- Acute injury or inflammation
- Pregnancy
- Impaired circulation
- Poor thermal regulation
- Edema
- Cardiac insufficiency
- Metal in the area
- Over an open wound
- Over areas where topical counterirritants have recently been applied
- Demyelinated nerve

2. The use of cryotherapy is contraindicated for the following:

- Cold hypersensitivity
- Cold intolerance
- Cryoglobulinemia
- Paroxysmal cold hemoglobinuria
- Raynaud disease or phenomenon
- Over regenerating peripheral nerves
- Over an area with circulatory compromise or peripheral vascular disease

Precautions for cryotherapy include:

- Over the superficial branch of a nerve
- Over an open wound
- Hypertension
- Poor or insufficient sensation or mentation

3. The use of immersion hydrotherapy is contraindicated for the following:

- Cardiac instability
- Confusion or impaired cognition
- Maceration around a wound
- Bleeding
- Infection in the area to be immersed
- Bowel incontinence
- Severe epilepsy
- Suicidal patients

Precautions for full body immersion in hot or very warm water include:

- Pregnancy
- Multiple Sclerosis
- Poor thermal regulation

4. Contraindications for Traction include:

- Where motion is contraindicated
- Acute injury or inflammation
- Joint hypermobility or instability
- Peripheralization of symptoms with traction
- Uncontrolled hypertension

Precautions for Traction include:

- Structural diseases or conditions affecting the tissues in the area to be treated (e.g., tumor, infection, osteoporosis, RA, prolonged systemic steroid use, local radiation therapy)
- When pressure of the belts may be hazardous (e.g., with pregnancy, hiatal hernia, vascular compromise, osteoporosis)
- Displaced annular fragment
- Medial disc protrusion

- When severe pain fully resolves with traction
- Claustrophobia or other psychological aversion to traction
- Inability to tolerate prone or supine position
- Disorientation

Additional precautions for cervical traction:

- TMJ problems
- Dentures

5. The use of thermal shortwave diathermy (SWD) is contraindicated for the following

- Any metal in the treatment area or on/in the body.
- Malignancy
- Eyes
- Testes
- Growing epiphyses

Contraindications for all forms of SWD:

- Implanted or transcutaneous neural stimulators including cardiac pacemakers
- Pregnancy

Precautions for all forms of SWD:

- Near electronic or magnetic equipment
- Obesity
- Copper-bearing intrauterine contraceptive devices

6. Contraindications for use of Electrical Currents:

- Demand pacemakers, implantable defibrillator, or unstable arrhythmia
- Placement of electrodes over carotid sinus
- Areas where venous or arterial thrombosis or thrombophlebitis is present
- Pregnancy – over or around the abdomen or low back

Precautions for electrical current use:

- Cardiac disease
- Impaired mentation
- Impaired sensation

- Malignant tumors
- Areas of skin irritation or open wounds

7. Contraindications to the use of ultrasound include:
   - Malignant tumor
   - Pregnancy
   - Central Nervous Tissue
   - Joint cement
   - Plastic components
   - Pacemaker or implantable cardiac rhythm device
   - Thrombophlebitis
   - Eyes
   - Reproductive organs

Precautions for Ultrasound include:

- Acute inflammation
- Epiphyseal plates
- Fractures
- Breast implants

The use of therapeutic modalities such as, electrical muscle stimulation, SWD, thermotherapy, cryotherapy, ultrasound, laser/light therapy, immersion hydrotherapy, and mechanical traction with pediatric patients is contraindicated if the patient cannot provide the proper feedback necessary for safe application.

In addition to the contraindications listed above, there are a wide range of services which are considered unproven, pose a significant health and safety risk, are scientifically implausible and/or are not widely supported as evidence based. Such services would be considered not medically necessary and include, but are not limited to:

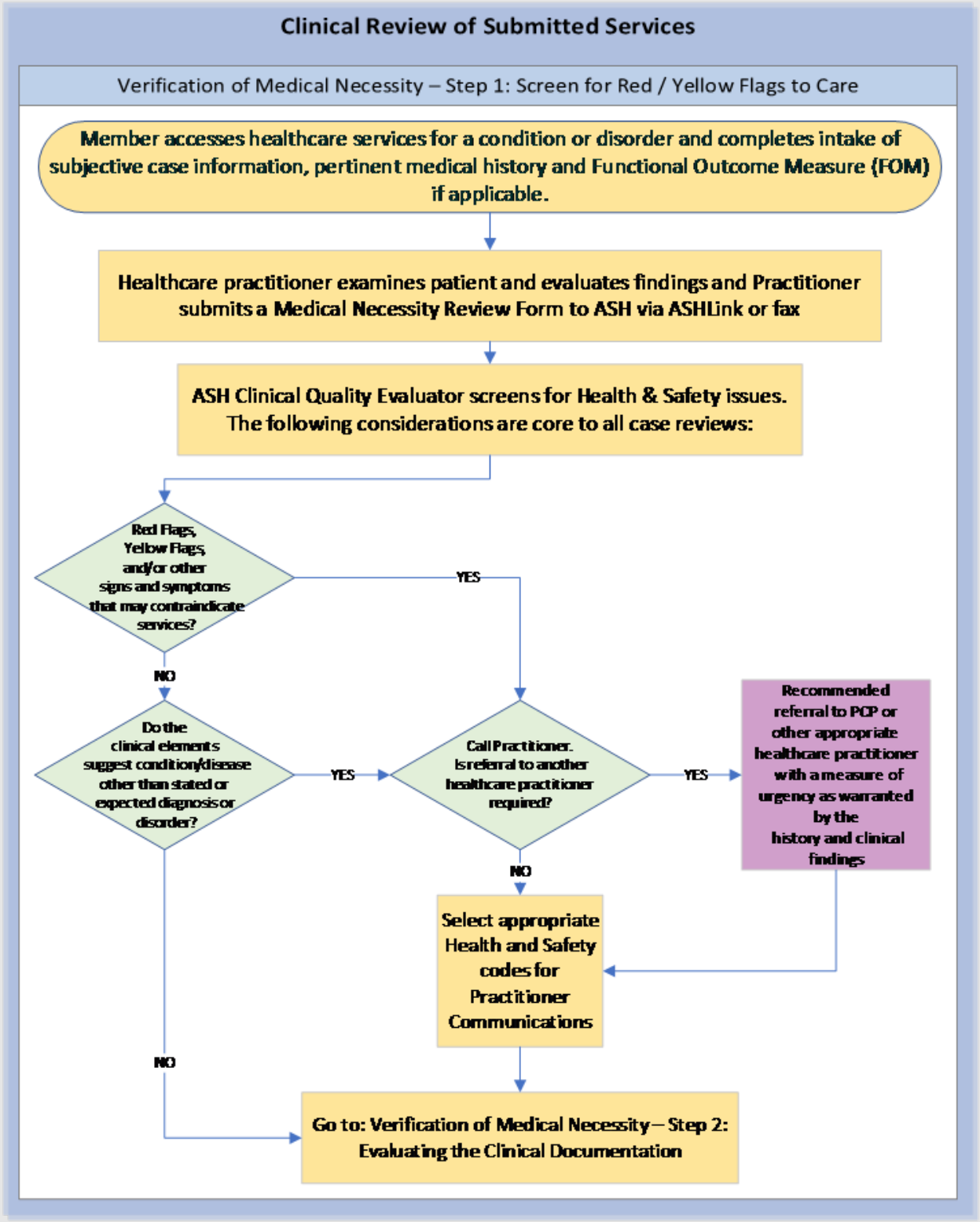
- Axial/Spinal decompression
- Dry needling
- Laser therapy
- Manual muscle testing to diagnosis non-neuromusculoskeletal conditions
- Microcurrent Electrical Nerve Stimulation (MENS)
- Other unproven procedures (see the *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133 – S)* clinical practice guideline for complete list)

**Diagnostic Imaging or Special Study** (e.g., CT, MRI, EMG, NCV, Other Laboratory Studies)

- Laboratory tests are performed only when medically necessary to improve diagnostic accuracy and treatment planning. Abnormal values are interpreted as they relate to the chief complaint or to unrelated co-morbid conditions that may or may not be contraindications to proposed treatment plan;
- X-ray procedures are performed only when medically necessary to improve diagnostic accuracy and treatment planning. *(*Indicators from history and physical examination indicating the need for x-ray procedures are described in the *X-Ray Guidelines (CPG 1 - S) policy)*;
- Advanced imaging studies, when medically necessary and/or available, are evaluated for structural integrity and to rule out osseous, related soft tissue pathology, or other pathology;
- EMG and NCV studies, when medically necessary and/or available, are evaluated for objective evidence of neural or muscular deficit. (Refer to *Electrodiagnostic Testing (CPG 129 - S)* for information);
- Imaging or special studies' findings are consistent with the condition; and
- Imaging or special studies' findings support a reasonable basis for the treatment submitted.

## Clinical Elements Considered by the Clinical Quality Evaluator

The following flow diagrams provide general clinical elements considered by the clinical quality evaluator when reviewing clinical documentation submitted by a treating practitioner. A single symptom or clinical finding, in isolation, generally will not define the appropriate approval or denial of services. The entire clinical picture must be taken into account. Specific contraindications to proposed interventions may result in denial of submitted services.

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To CQT for informational review 01/08/2024
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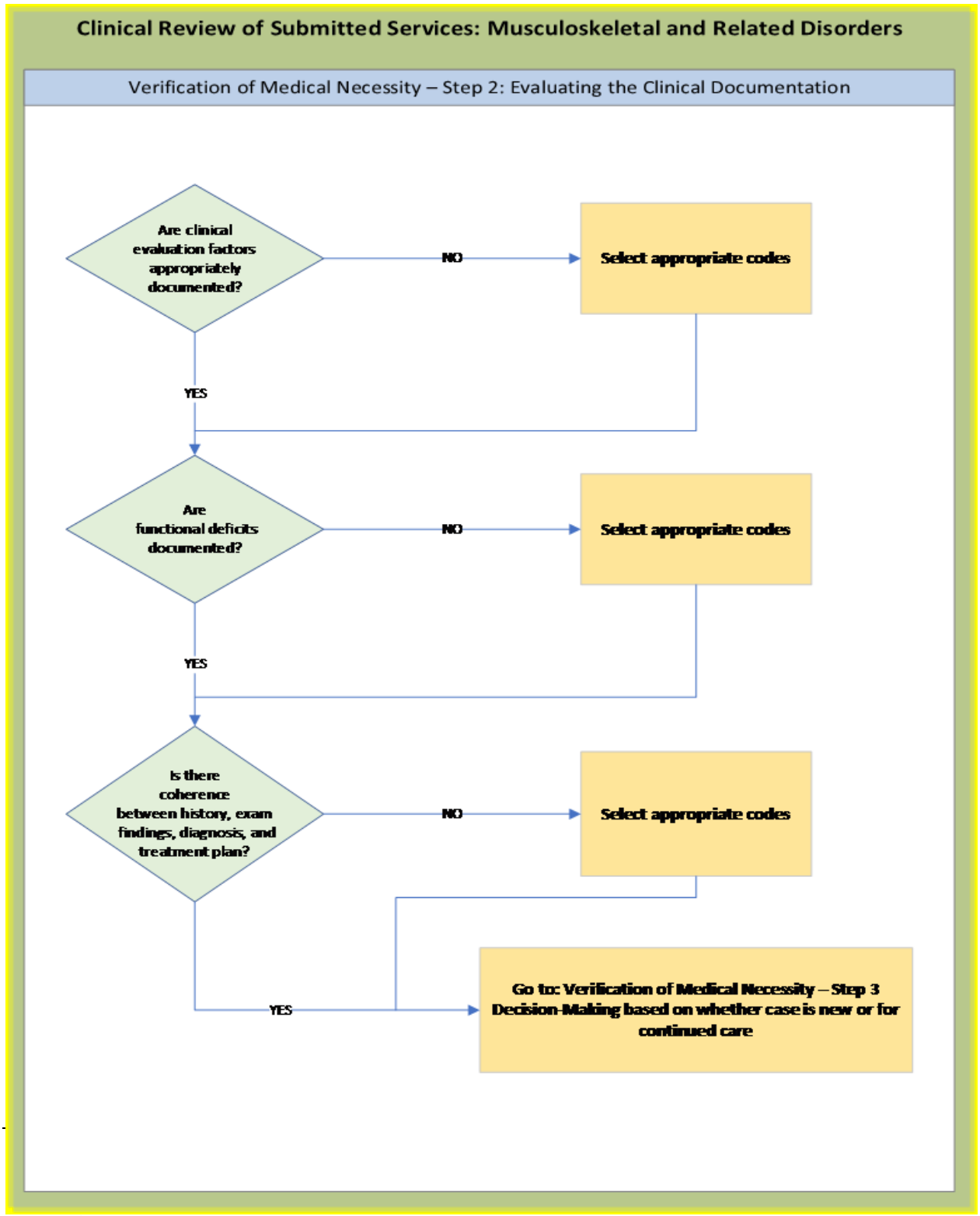


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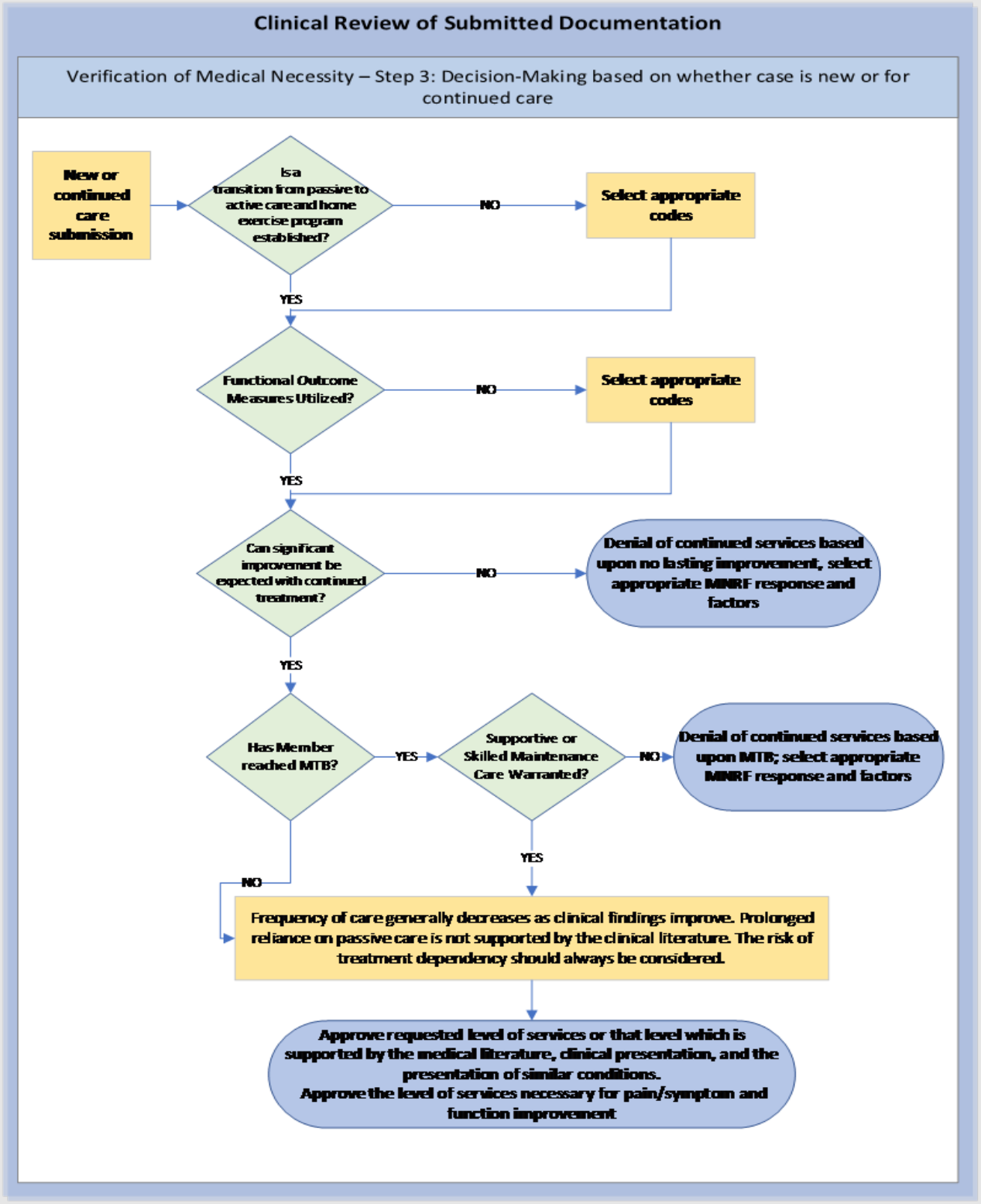


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## NEED FOR REFERRAL OR COORDINATION OF SERVICES

When a potential health and safety issue is identified, the CQE must communicate with the provider of services as soon as possible by telephone and/or through standardized communication methods to recommend returning the patient back to the referring health care practitioner or referring the patient to other appropriate health care practitioner/specialist with the measure of urgency as warranted by the history and clinical findings.

Clinical factors that may require referral or coordination of services include, but not limited to:

- Symptoms worsening following treatment;
- Deteriorating condition (e.g., orthopedic or neurologic findings, function, etc.);
- Reoccurring exacerbations despite continued treatment;
- No progress despite treatment;
- Unexplained diagnostic findings (e.g., suspicion of fracture);
- Identification of Red Flags;
- Identification of co-morbid conditions that do not appear to have been addressed previously that represent absolute contraindications to services;
- Constitutional signs and symptoms indicative of systemic condition (e.g., unintended weight loss of greater than 4.5 kg/10 lbs. over 6-month period);
- Inability to provoke symptoms with standard exam;
- Treatment needed outside of scope of practice.

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