Clinical Practice Guideline: **Occupational Therapy Medical Policy/Guidelines**

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Product: **Specialty**

Related Policies:
CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care
CPG 30: Laser Therapy (LT)
CPG 110: Medical Record Maintenance and Documentation Policies
CPG 111: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations
CPG 112: Exercise Therapy for Treatment of Non-Specific Low Back Pain
CPG 113: Exercise Therapy for Treatment of Neck Pain
CPG 121: Passive Physiotherapy Modalities
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CPG 305: Virtual Physical Therapy and Rehabilitation Services

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DESCRIPTION

This document addresses Occupational Therapy Services which may be delivered by an Occupational Therapist acting within the scope of a professional license. This document also addresses the processes associated with Medical Necessity Determinations performed by American Specialty Health (ASH) clinical quality evaluators on services submitted for review.

The availability of coverage for rehabilitative and/or habilitative services will vary by benefit design as well as by State and Federal regulatory requirements. Benefit plans may include a maximum allowable rehabilitation benefit, either in duration of treatment or in number of visits or in the conditions covered or type of services covered. When the maximum allowable benefit is exhausted or if the condition or service are not covered, coverage will no longer be provided even if the medical necessity criteria described below are met.

GUIDELINES

1. PROVIDERS OF OCCUPATIONAL THERAPY SERVICES

Covered, medically necessary rehabilitative or habilitative services must be delivered by a qualified Occupational Therapist acting within the scope of their license as regulated by the Federal and State governments. Some services may be performed by ancillary providers (e.g., licensed occupational therapy assistant) under the direction and supervision of, and in collaboration with, a licensed Occupational Therapist; however, generally, only those healthcare practitioners who hold an active license, certification, or registration with the applicable state board or agency may provide such services. Benefits for services provided by these ancillary healthcare providers may also be dependent upon the patient's benefit contract language.

Aides and other nonqualified personnel are limited to provision of non-skilled services such as preparing the individual, treatment area, equipment, or supplies; assisting a qualified therapist or assistant; and transporting individuals.

According to the American Occupational Therapy Association, occupational therapists and occupational therapy assistants help people across their lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Occupational therapists provide services to patients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes. OT addresses physical, cognitive, psychosocial, sensory, communication, and other areas of performance in various contexts and environments in everyday life activities that affect health, well-being, and quality of life. The overarching goal of occupational therapy is “to support [people’s] health and participation in life through engagement in occupations.”

A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

Services that do not require the professional skills of a therapist to perform or supervise are not medically necessary, even if they are performed or supervised by a therapist, physician or NPP. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self-management program, restorative nursing program or caregiver assisted program, occupational therapy services are not indicated or medically necessary. Occupational therapy is used for both rehabilitation and habilitation. Skilled occupational therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The plan of care for medically necessary occupational therapy services is established by a licensed occupational therapist. The amount, frequency and duration of the occupational therapy services must be reasonable (within regional norms and commonly accepted practice patterns); the services must be considered appropriate and needed for the treatment of the condition and must not be palliative in nature. Thus, once therapeutic benefit has been achieved, or a home exercise program could be used for further gains without the need for skilled occupational therapy, continuing supervised occupational therapy is not considered medically necessary.

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. If no improvement is documented after two weeks of treatment, an alternative treatment plan should be attempted. Treatment is no longer medically necessary when the individual stops progressing toward established goals.

Habilitative services are defined by the National Association of Insurance Commissioners as "health care services that help a person keep, learn or improve skills and functioning for daily living." 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. Examples include therapy for a child who is not walking at the expected age.

Note: The availability of rehabilitative and/or habilitative benefits for occupational therapy services, state and federal mandates, and regulatory requirements should be verified and followed in addition to the benefit plan provisions and medical necessity criteria defined in this document.

2. REHABILITATIVE OCCUPATIONAL THERAPY SERVICES

Medically Necessary

(1) Rehabilitative occupational therapy (OT) services to improve, adapt, compensate, or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality are considered **medically necessary** when **ALL** the following criteria are met*:*

1. The services are delivered by a qualified provider of occupational therapy services (i.e., appropriately trained and licensed by the state to perform occupational therapy services); and
2. Rehabilitative occupational therapy occurs when the judgment, knowledge, and skills of a qualified provider of occupational therapy services (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service due to the complexity and sophistication of the plan of care and the medical condition of the individual, with the goal of improvement of an impairment or functional limitation.
3. The patient demonstrates a physical and/or functional impairment as demonstrated by the inability to perform basic activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or usual daily activities.
4. The patient demonstrates signs and symptoms of physical and/or functional impairment in one or more of the following areas:
    a. Sensory and/or motor
    b. Cognitive/psychological
    c. Cardiopulmonary status and circulation
    d. Skin
5. The patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a **reasonable and generally predictable period of time*** and will result in a clinically significant level of functional improvement; and
6. Improvement or restoration of function could not be reasonably expected as the individual gradually resumes normal activities without the provision of skilled rehabilitative services; and
7. The documentation objectively verifies progressive functional improvement over specific time frames and clinically justifies the initiation of continuation of rehabilitative services; and

8. The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

***Reasonable and predictable period of time:** The specific time frames in which one would expect practical functional improvement is dependent on various factors including whether the services are Rehabilitative or Habilitative services. A reasonable trial of care for rehabilitative services to determine the patient's potential for improvement in or restoration of function is influenced by the diagnosis; clinical evaluation findings; stage of the condition (acute, sub-acute, chronic); severity of the condition; and patient-specific elements (age, gender, past and current medical history, family history, and any relevant psychosocial factors). Habilitative services may be prolonged and are primarily influenced by the type of ADLs or IADLs which have not developed, or which are at risk of being lost.

(2) An occupational therapy evaluation is considered medically necessary for the assessment of a physical impairment.

Not Medically Necessary

(1) Rehabilitative OT services are considered not medically necessary if any of the following is determined:

1. Rehabilitative services are NOT 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.
2. Improvement or restoration of function could reasonably be expected to improve as the individual gradually resumes normal activities without the provision of skilled therapy services. For example:
    - A patient suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.
    - A fully functional patient who develops temporary weakness from a brief period of bed rest following abdominal surgery.
3. Therapy services that do not require the skills of a qualified provider of OT services. Examples include but are not limited to:
    - General exercises (basic aerobic, strength, flexibility, or aquatic programs) to promote overall fitness/conditioning.
    - Services for the purpose of enhancing athletic or recreational sports performance or for return to sport after injury or surgery.
    - Massages and whirlpools for relaxation.
    - General public education/instruction sessions.
    - Repetitive gait or other activities and services that an individual can practice independently and can be self-administered safely and effectively.

a) Activities that require only routine supervision and NOT the skilled services of an occupational therapy provider.
b) When a home exercise program is sufficient and can be utilized to continue therapy (examples of exceptions include but would not be limited to the following: if patient has poor exercise technique that requires cueing and feedback, lack of support at home if necessary for exercise program completion, and/or cognitive impairment that doesn't allow the patient to complete the exercise program).

4. The expectation does **not** exist that the service(s) will result in a clinically significant improvement in the level of functioning within a reasonable and predictable period of time (up to 4 weeks).
    - If function could reasonably be expected to improve as the individual gradually resumes normal activities, then the service is considered **not** medically necessary.
    - The patient's condition does not have the potential to improve or is not improving in response to therapy; or would be insignificant relative to the extent and duration of therapy required; and there is an expectation that further improvement is NOT attainable.
    - The documentation fails to objectively verify functional progress over a reasonable period of time (up to 4 weeks).
    - The patient has reached maximum therapeutic benefit.
5. A passive modality is **not** preparatory to other skilled treatment procedures or is not necessary in order to provide other skilled treatment procedures safely and effectively.
6. A passive modality has insufficient published evidence to support a clinically meaningful physiologic effect on the target tissue or improve the potential for a positive response to care for the condition being treated.
7. Reevaluations or assessments of a patient's status that are not separate and distinct services from those work components included within occupational therapy services provided.
8. Reevaluations or assessments of a patient's status that are not necessary to continue a course of therapy nor related to a new condition or exacerbation for which the reevaluation will likely result in a change in the treatment plan.
9. The treatments/services are not supported by and are not performed in accordance with peer-reviewed literature as documented in appliable ASH CPGs or other literature accepted by ASH Clinical Quality committee.

(2) The following treatments/programs are not considered medically necessary because they are nonmedical, non-rehabilitative, educational, or training in nature. In addition, these treatments/programs, may be specifically excluded under many benefit plans:

- Back school
- Driving safety/driver training
- Vocational rehabilitation programs and any program or evaluation with the primary goal of returning an individual to work
- Work hardening programs
- Health and wellness intervention
- Education and achievement testing, including Intelligence Quotient (IQ) testing.
- Educational interventions (e.g., classroom environmental manipulation, academic skills training and parental training).
- Services provided within the school setting and duplicated in the rehabilitation setting.

(3) Use of the any of the following treatments is unproven. Refer to *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133)* and/or the specific guideline below for additional information.

1. Intensive model of constraint-induced movement therapy
2. Intensive Model of Therapy (IMOT) programs *[Intensive Model of Therapy (CPG 286 - S)]*
3. Dry hydrotherapy/aqua massage/hydromassage
4. Non-invasive Interactive Neurostimulation (e.g., InterX®) [*Non-invasive Interactive Neurostimulation* (e.g., InterX®) (*CPG 277 – S)]*
5. Microcurrent Electrical Nerve Stimulation (MENS)
6. H-WAVE ® *[H-WAVE® Electrical Stimulation (CPG 269 – S)]*
7. Equestrian therapy (e.g., hippotherapy)
8. MEDEK Therapy [*MEDEK Therapy (CPG 276 – S)]*
9. The Interactive Metronome Program
10. Elastic therapeutic tape/taping (e.g., Kinesio™ tape, KT TAPE/KT TAPE PRO™, Spidertech™ tape) [*Strapping and Taping (CPG 143 – S)]*
11. Dry Needling [*Dry Needling (CPG 178 – S)]*
12. Laser therapy [*Laser Therapy (LT) (CPG 30 – S)]*

3. MAINTENANCE OCCUPATIONAL THERAPY SERVICES

According to the Centers for Medicare and Medicaid Services (CMS) guidelines, or when covered by private carriers, maintenance occupational therapy services are a covered benefit when skilled occupational therapy care is medically necessary to maintain functional status or to prevent or slow further deterioration in function. Unlike coverage for rehabilitative therapy, coverage for maintenance therapy does not depend on the presence or absence of a patient's potential for improvement for therapy; the deciding

factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist.

If the specialized skill, knowledge and judgment of a qualified occupational therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, **the establishment or design of a maintenance program is medically necessary.**

If skilled occupational therapy services by a qualified occupational therapy therapist, or occupational therapy assistant under the supervision of a qualified therapist, are needed to instruct the patient or appropriate caregiver regarding the maintenance program, **such instruction is medically necessary**.

If skilled occupational therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such **periodic reevaluations or reassessments are medically necessary.**

Once a maintenance program is designed or established, a maintenance program can generally be performed by the patient alone or with the assistance of family member, caregiver or unskilled personnel. In such situations, coverage is not medically necessary. The performance or delivery of the maintenance therapy program is considered medically necessary only when the documentation establishes that the following criteria has been met:

1. The individualized assessment of a patient's clinical condition demonstrates that the specialized judgment, knowledge and skills of an occupational therapy practitioner (skilled care) are necessary for the performance of an effective maintenance program.
2. When the needed therapy procedures required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified occupational therapy practitioner (as defined by scope of practice in each state) are required to furnish the therapy procedure or
3. The particular patient's special medical complications require the skills of a qualified occupational therapy practitioner to furnish a therapy service required to maintain the patient's current function or to prevent or slow further deterioration, even if the skills of an occupational therapy practitioner are not ordinarily needed to perform such therapy procedures.

The plan of care must be developed by the physician, NPP (non-physician practitioner) or OT who will provide the OT services.

4. HABILITATIVE OCCUPATIONAL THERAPY SERVICES

Habilitative services may or may not be covered services. If the member's contract excludes habilitative services, the contract prevails.

Medically Necessary

(1) Habilitative OT services are considered medically necessary when ALL the following criteria are met:

1. The therapy is intended to maintain or develop 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 (including developmental delay), injury, loss of a body part, or congenital abnormality.
2. The occupational therapy services are evidence-based and require the judgment, knowledge, and skills of a qualified provider of occupational therapy services due to the complexity and sophistication of the plan of care and the medical condition of the individual.
3. There is an expectation that the therapy will assist development of function or maintain an acceptable level of functioning.
4. An individual would either not be expected to develop the function or would be expected to permanently lose the function (not merely experience fluctuation in the function) without the habilitative service. If the undeveloped or impaired function is not the result of a loss of body part or injury, a physician experienced in the evaluation and management of the undeveloped or impaired function has confirmed that the function would not either be expected to develop or would be permanently lost without the habilitative service. This information also concurs with the written treatment plan, which is likely to result in meaningful development of function or prevention of the loss of function.
5. There is a written treatment plan documenting the short and long-term goals (including estimated time when goals will be met) of treatment, frequency and duration of treatment, and what quantitative outcome measures will be used to assess function objectively.
6. Documentation objectively verifies that, at a minimum, functional status is maintained or developed.
7. The services are delivered by a qualified provider of occupational therapy services.

Not Medically Necessary

(1) Habilitative OT services are considered not medically necessary if any of the criteria above are not met.

5. REDUNDANT THERAPEUTIC EFFECTS AND REHABILITATIVE OR HABILITATIVE SERVICES

1. Redundant rehabilitative or habilitative therapy services expected to achieve the same therapeutic goal are considered not medically necessary and it would be inappropriate to provide these services to the same body region during the same treatment session. This includes treatments, such as but not limited to:
    - multiple modalities procedures that have similar or overlapping physiologic effects (e.g., multiple forms of superficial or deep heating modalities).
    - massage therapy and myofascial release.
    - orthotics training and prosthetic training.
    - whirlpool and Hubbard tank.

2. Duplicative (same or similar) rehabilitative or habilitative therapy services provided as part of an authorized therapy program through another therapy discipline are not medically necessary and inappropriate in the provision of care for the same patient.
    - When individuals receive physical, occupational, or speech therapy, the therapists should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals. This applies to chiropractic services as well.
    - As an example, when individuals receive manual therapy services from an occupational therapist and chiropractic or osteopathic manipulation, the services must be documented as separate and distinct, performed on different body parts, and must be justified and non-duplicative.

6. THERAPEUTIC MODALITIES AND PROCEDURES

In some states, occupational therapists are required to hold a specific certification to use modalities in practice. The CPT codebook defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy.” Modalities may be supervised, which means that the application of the modality doesn’t require direct one-on-one patient contact by the practitioner. Or modalities may involve constant attendance, which indicates that the modality requires direct one-on-one patient contact by the practitioner.

Supervised modalities are untimed therapies. Untimed therapies are usually reported only once for each date of service regardless of the number of minutes spent providing this service or the number of body areas to which they were applied. Untimed services billed as more than one unit will require significant documentation to justify treatment greater than one session per day. Examples of supervised modalities include application of:

- Hot or cold packs
- Mechanical traction
- Unattended electrical stimulation
- Vasopneumatic devices
- Whirlpool
- Paraffin bath
- Diathermy

Modalities that require constant attendance, are timed and reported in 15-minute increments (one unit) regardless of the number of body areas to which they are applied. Examples of modalities that require constant attendance include:

- Contrast baths
- Ultrasound
- Electrical stimulation
- Iontophoresis

The CPT codebook defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function." Except for Group Therapy (97150) and Work Hardening/Conditioning (97545-6), therapeutic procedures require direct (one-on-one) patient contact by the Occupational Therapist, are timed therapies, and must be reported in units of 15-minute increments. Only the actual time that the Occupational Therapist is directly working with the patient performing exercises/activities, instruction, or assessments is counted as treatment time. The time that the patient spends not being treated because of a need for rest or equipment set up is not considered treatment time. Any exercise/activity that does not require, or no longer requires, the skilled assessment and intervention of a health care practitioner is not considered a medically necessary therapeutic procedure. Exercises often can be taught to the patient or a caregiver as part of a home/self-care program. Examples of therapeutic procedures that require the Occupational Therapist to have direct (one-on-one) patient contact include:

- therapeutic exercises
- neuromuscular reeducation
- gait training
- manual therapy (e.g., soft tissue mobilization)
- therapeutic activities
- sensory integrative techniques
- wheelchair training

Documentation Requirements to Substantiate Medical Necessity of Therapeutic Modalities and Procedures

Proper and sufficient documentation is essential to establish the clinical necessity and effectiveness of each modality and procedure, aid in the determination of patient outcomes management, and support continuity of patient care. At a minimum, documentation is required for every treatment day and for each therapy performed. Each daily record should include: the date of service, the name of each modality and/or procedure performed, the parameters for each modality (e.g., amperage/voltage, location of pads/electrodes), area of treatment, total treatment time spent for each therapy (mandatory for timed services), the total treatment time for each date of service, and the identity of the person(s) providing the services. Failure to properly identify and sufficiently document the parameters for each therapy on a daily progress note may result in an adverse determination (partial approval or denial).

6.1 Passive Care and Active Care

Generally, passive modalities are used to manage the acute inflammatory response, pain, and/or muscle tightness or spasm in the early stages of musculoskeletal and related condition management. They are most effective during the acute phase of treatment. The use of passive modalities in the treatment of sub-acute or chronic conditions beyond the acute inflammatory response time frame is generally considered not medically necessary unless there is an exacerbation. Passive modalities are rarely beneficial alone and are most effective when performed as part of a comprehensive treatment approach. Some improvement with the use of passive modalities should be seen within three visits. If passive therapy is not contributing to improvement, passive therapy should be discontinued and other evidence supported interventions implemented. The use of passive modalities is generally considered not medically necessary unless they are preparatory and essential to the safe and effective delivery of other skilled treatment procedures (e.g., therapeutic exercise training). Prolonged reliance on passive modalities is not supported by the clinical literature.

A “passive therapy” is a procedure applied by a clinical practitioner without active engagement of or movement by the patient (e.g., ultrasound, hot packs).

The selection of a passive modality should be based on an understanding of the known physiologic effects of the modality, contraindications, the stage of injury and/or tissue healing, anatomical location to be treated, patient specific conditions and the likelihood of the therapy to enhance recovery or facilitate treatment with manual and active therapeutic procedures. Use of more than two (2) modalities on each visit date is unusual and should be justified in the documentation.

Transition from passive physiotherapy modalities to active treatment procedures should be timely and evidenced in the medical record, including instructions on self/home care. Active therapeutic procedures are typically started as swelling, pain, and inflammation are reduced. Active care elements include increasing range of motion, strengthening primary and secondary stabilizers of a given region, and increasing the endurance capability of the muscles. Care focuses on active participation of the patient in their exercise program. Activities of Daily Living (ADLs) training, muscle strengthening, movement retraining, and progressive resistive exercises are considered active procedures. Patients should progress from active procedures requiring the supervision of a skilled practitioner to a self-directed home activity program as soon as possible.

6.2 Treatment Interventions

Below are descriptions and medical necessity criteria, as applicable, for different treatment interventions, including specific modalities and therapeutic procedures associated with occupational therapy. This material is for informational purposes only and is not indicative of coverage, nor is it an exhaustive list of services provided.

Hydrotherapy/Whirlpool/Hubbard Tank

These modalities involve supervised use of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds e.g., ulcers, skin conditions. Hydrotherapy may be considered medically necessary for pain relief, muscle relaxation and improvement of movement for persons with musculoskeletal conditions or for wound care (cleansing and debridement).

Fluidotherapy®

This modality is used specifically for acute and subacute conditions of the extremities. Fluidotherapy® is a dry superficial thermal modality that transfers heat to soft tissues by agitation of heated air and Cellux particles. The indications for this modality are similar to paraffin baths and whirlpool and it is an acceptable alternative to other heat modalities for reducing pain, edema, and muscle spasm from acute or subacute traumatic or non-traumatic musculoskeletal disorders of the extremities, including complex regional pain syndrome (CRPS). A benefit of Fluidotherapy® is that patients can perform active range of motion (AROM) while undergoing treatment.

Vasopneumatic Devices

These special devices apply pressure for swelling/edema reduction, either after an acute injury, following a surgical procedure, due to lymphedema, or due to pathology such as venous insufficiency. Education sessions for home use are considered medically necessary (up to two sessions). Cooling systems such as Game Ready® Systems, Cryocuff, Polar Care Wave or any similar cold compression system devices are not considered vasopneumatic devices and should not be billed as such.

Hot/Cold Packs

Hot packs increase blood flow, relieve pain and increase flexibility. Cold packs decrease blood flow to an area for reduction of pain and swelling. They may be considered medically necessary for musculoskeletal conditions that include significant pain and/or swelling.

Paraffin Bath

This modality uses hot wax for application of heat. It is indicated for use to relieve pain and increase range of motion of extremities (typically wrists and hands) due to chronic joint problems, post-injury, or post-surgical scenarios.

Infrared Light Therapy

Infrared light therapy is a form of heat therapy used to increase circulation to relieve muscle spasm. Other heating modalities are considered superior to infrared lamps and should be considered unless there is a contraindication to those other forms of heat. Utilization of the Infrared Light Therapy CPT code is not appropriate for low level laser treatment. This also does not refer to Anodyne® Therapy System.

Electrical Stimulation

Electrical stimulation is used in different variations to relieve pain, reduce swelling, heal wounds, and improve muscle function. Functional electric stimulation is considered medically necessary for muscle re-education (to improve muscle contraction) in the earlier phases of rehabilitation.

Iontophoresis

Electric current is used to transfer certain chemicals (medications) into body tissues. Use of iontophoresis may be considered medically necessary for the treatment of inflammatory conditions, such as plantar fasciitis and lateral epicondylitis.

Contrast Baths

This modality is the application of alternative hot and cold baths and is typically used to treat extremities with subacute swelling or chronic regional pain syndrome (CRPS). Contrast baths may be considered medically necessary to reduce hypersensitivity and swelling.

Ultrasound

This modality provides deep heating through high frequency sound wave application. Non-thermal applications are also possible using the pulsed option. Ultrasound is commonly used to treat many soft tissue conditions that require deep heating or micromassage to a localized area to relieve pain and improve healing. Ultrasound may be considered medically necessary to relieve pain and improve healing.

Diathermy (e.g., shortwave)

Shortwave diathermy utilizes high frequency magnetic and electrical current to provide deep heating to larger joints and soft tissue, and may be considered medically necessary for pain relief, increased circulation, and muscle spasm reduction. Microwave diathermy presents an unacceptable risk profile and is considered not medically necessary.

Therapeutic Exercises

Therapeutic exercise includes instruction, feedback, and supervision of a person in an exercise program specific to their condition. Therapeutic exercise may be considered medically necessary to restore/develop strength, endurance, range of motion and flexibility which has been lost or limited as a result of a disease or injury. Exercise performed by the patient within a clinic facility or other location (e.g., home; gym) without a physician or therapist present and supervising would be considered not medically necessary.

Neuromuscular Reeducation (NMR)

NMR generally refers to a treatment technique performed for the purpose of retraining the connection of the brain and muscles, via the nervous system, to improve movement, strength, balance, and function. The goal of NMR is to develop conscious control of individual muscles and awareness of position of extremities. The procedure may be considered medically necessary for impairments which affect the neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident and systemic neurological disease. Example techniques may include proprioceptive neuromuscular facilitation (PNF), BAP's boards, vestibular rehabilitation, desensitization techniques. This does not include contract/relax or other soft tissue massage techniques. NMR is typically used as the precursor to the implementation of Therapeutic Activities.

Aquatic Therapy

Pool therapy (aquatic therapy) is provided individually, in a pool, to debilitated or neurologically impaired individuals. (The term is not intended to refer to relatively normal functioning individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.) The goal is to develop and/or maintain muscle strength and range of motion by reducing forces of gravity through total or partial body immersion (except for head). Aquatic therapy may be considered medically necessary to develop and/or maintain muscle strength and range of motion when it is necessary to reduce the force of gravity through partial body immersion.

Soft Tissue Mobilization

Soft tissue mobilization techniques are more specific in nature and include, but are not limited to, myofascial release techniques, friction massage, and trigger point techniques. Specifically, myofascial release is a soft tissue manual technique that involves

manipulation of the muscle, fascia, and skin. Skilled manual techniques (active and/or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue. This procedure is considered medically necessary for treatment of pain and restricted motion of soft tissues resulting in functional deficits.

Joint Mobilization

Joint mobilization is utilized to reduce pain and increase joint mobility. Most often mobilizations are indicated for the upper extremity, especially the hand.

Therapeutic Activities

Therapeutic activities or functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities may be considered medically necessary) to improve function when there has been a loss or restriction of mobility, strength, balance or coordination. These dynamic activities must be part of an active treatment plan and directed at a specific outcome. As an example, this intervention may be considered medically necessary after a patient has completed exercises focused on strengthening and range of motion but needs to improve function-based activities.

Activities of Daily Living (ADL) Training

This procedure is considered medically necessary to enable the patient to perform essential activities of daily living, instrumental activities of daily living, and self-care including bathing, feeding, preparing meals, toileting, dressing, walking, making a bed, and transferring from bed to chair, wheelchair or walker. Services provided concurrently by physical therapists and occupational therapists may be considered medically necessary if there are separate and distinct functional goals.

Cognitive Skills Development

This procedure is considered medically necessary for persons with acquired cognitive deficits resulting from head trauma, or acute neurologic events including cerebrovascular accident, pediatric developmental condition, or other situations. It is not appropriate for persons without potential for improvement. Occupational therapists and speech language pathologists with specific training typically provide this care. This procedure should be aimed at improving or restoring specific functions which were impaired by an identified illness or injury.

Sensory Integration

Sensory integration involves perceiving, modulating, organizing, and interpreting these sensations to optimize occupational performance and participation. Sensory integration is mainly an intervention for children with developmental and behavioral disorders. The activities included in SI provide vestibular, proprioceptive, auditory, and tactile stimuli, which in turn

organize the sensory system. See CPG 149 Sensory Integrative (SI) Therapy for medical necessity criteria.

Orthotic Management and Training

Orthotic management and training may be considered medically necessary when the documentation specifically demonstrates that the specific knowledge, skills, and judgment of an Occupational Therapist are required to train the patient in the proper use of braces and/or splints (orthotics). Many braces or splints do not require specific training by the Occupational Therapist in their use and can be safely procured and applied by the patient. Patients with cognitive, dexterity, or other significant deficits may need specific training where other patients do not.

Prosthetic Training

Prosthetic training may be considered medically necessary when the professional skills of the practitioner are required to train the patient in the proper fitting and use of a prosthetic (an artificial body part, such as a limb). Periodic return visits beyond the third month may be necessary.

Wheelchair Management Training

This procedure is considered medically necessary only when it is part of an active treatment plan directed at a specific goal. The member must have the capacity to learn from instructions. Typically, three (3) sessions are adequate.

Active Wound Care Management

The CPT codebook defines active wound care procedures as those procedures "performed to remove devitalized tissue and/or necrotic tissue and promote healing" (AMA, current year). The practitioner is required to have direct one-on-one contact with the patient. Examples of active wound care management include non-selective debridement of an open wound, including topical application; use of whirlpool or other modalities; and negative pressure wound therapy. Occupational therapy state rules and regulations will dictate if occupational therapists can perform wound care.

Lymphedema Management

For more information, see the *Lymphedema (CPG 157 – S)* clinical practice guideline.

6.3 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 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 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)

7. CLINICAL DOCUMENTATION

Medical record keeping is an essential component of patient evaluation and management. Medical records should be legible and should contain, at a minimum sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. Good medical record keeping improves the likelihood of a positive outcome and reduces the risk of treatment errors. It also provides a resource to review cases for opportunities to improve care, provides evidence for legal records, and offers necessary information for third parties who need to review and understand the rationale and type of services rendered (e.g., medical billers and auditors/reviewers).

Outcome measures are important in determining effectiveness of a patient's care. The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures provide information about whether predicted outcomes are being realized. When comparison of follow-up with baseline outcome metrics does not demonstrate minimal

clinically important difference (MCID) (minimal amount of change in a score of a valid outcome assessment tool) the treatment plan should be changed or be discontinued. Failure to use Functional Outcome Measures (FOMs) / Outcome Assessment Tools (OATs) may result in insufficient documentation of patient progress and may result in an adverse determination (partial approval or denial) of continued care.

7.1 Evaluation and Re-evaluations

The initial evaluation is usually completed in a single session. The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient/caregiver self-reporting. Initial evaluations are completed to determine the medical necessity of initiating rehabilitative therapy or skilled instruction in maintenance activities that the patient and/or caregiver can perform at home. The occupational therapist performs an initial examination and evaluation to establish a working diagnosis, prognosis, and plan of care prior to intervention. Determination of referral to another health care practitioner is also an essential part of an initial evaluation. An initial evaluation for a new condition by an Occupational Therapist is defined as the evaluation of a patient:

- For which this is their first encounter with the practitioner or practitioner group;
- Who presents with:
  - A new injury or new condition; or
  - The same or similar complaint after discharge from previous care.
- Choice of code is dependent upon the level of complexity.

The evaluation codes reflect three (3) levels of patient presentation:

1. low complexity;
2. moderate complexity; and
3. high complexity.

Four (4) components are used to select the appropriate occupational therapy evaluation CPT code. These include:

1. Occupational profile and client history (medical and therapy);
2. Assessments of occupational performance;
3. Clinical decision making;
4. Development of plan of care.

Relevant CPT Codes: 97165, 97166, and 97167 – Occupational Therapy evaluation.

The occupational therapist evaluation:

- Is documented, dated, and appropriately authenticated by the occupational therapist who performed it
- Identifies the occupational therapy needs of the patient
- Incorporates appropriate tests and measures to facilitate outcome measurement
- Produces data that are sufficient to allow evaluation, prognosis, and the establishment of a plan of care

The written plan of care should be sufficient to determine the medical necessity of treatment, including:

- The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis
- A reasonable estimate of when the goals will be reached
- Long-term and short-term goals that are specific, quantitative and objective
- Occupational therapy evaluation pertinent findings
- The frequency and duration of treatment
- Rehabilitation or habilitation prognosis
- The specific treatment techniques and/or exercises to be used in treatment
- Signatures of the patient's occupational therapist

Re-evaluations are distinct from therapy assessments. There are several routine reassessments that are not considered re-evaluations. These include ongoing reassessments that are part of each skilled treatment session, progress reports, and discharge summaries. Re-evaluation provides additional objective information not included in documentation of ongoing assessments, treatment or progress notes. Assessments are considered a routine aspect of intervention and are not billed separately from the intervention. Continuous assessment of the patient’s progress is a component of the ongoing therapy services and is not payable as a re-evaluation.

Re-evaluation services are considered medically necessary when **ALL** of the following conditions are met:

- Re-evaluation is not a recurring routine assessment of patient status;
- The documentation of the re-evaluation includes all of the following elements:
  - An evaluation of progress toward current goals;
  - Making a professional judgment about continued care;
  - Making a professional judgment about revising goals and/or treatment or terminating services.

AND the following indication is documented:
An exacerbation or significant change in patient/client status or condition.

Relevant CPT Codes: 97168 – Occupational Therapy re-evaluation

In order to reflect that continued OT services are medically necessary, intermittent progress reports must demonstrate that the individual is making functional progress.

7.2 Treatment Sessions

An occupational therapy intervention is the purposeful interaction of the occupational therapy practitioner (OT or OTA) with the patient and, when appropriate, with other individuals involved in patient care, using various occupational therapy procedures and techniques to produce changes in the condition that are consistent with the diagnosis and prognosis. Occupational therapy interventions consist of coordination, communication, and documentation; patient-related and family/caregiver instruction; and procedural interventions. Occupational therapists aim to alleviate impairment and functional limitation by designing, implementing, and modifying therapeutic interventions. An occupational therapy session can vary in duration; however, treatment sessions lasting more than one hour per day are infrequent in outpatient settings (payor medical or reimbursement coverage policy may limit unit or session duration per date of service). Treatment sessions for more than one hour per day may be medically appropriate but must be supported in the documented plan of care and based on a patient's medical condition. An occupational therapy session may include:

- Evaluation or reevaluation
- Therapeutic use of everyday life and other purposeful activities, and other interventions focusing on preparing patients for daily activities performed in life and work
- Basic and advanced functional training in daily living, self-care and home management including activities of daily living (ADL) and instrumental activities of daily living (IADL)
- Management of feeding, eating and swallowing to improve eating and feeding performance
- Cognitive, perceptual, safety and judgment evaluation and training
- Adaptive training in and modification of activities, processes and environments (home, work, school, or community), including ergonomic applications and performance improvement
- Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices
- Training in the use of prosthetic devices
- Higher level independent living skill instruction and community/work functional reintegration
- Functionally oriented upper extremity interventions
- Training of the patient, caregivers, and family/parents in home exercise and activity programs
- Skilled reassessment of the individual's problems, plan, and goals as part of the treatment session

Documentation of each treatment session should include at a minimum:

- Date of treatment;
- Subjective complaints and current status (including functional deficits and ADL restrictions);
- Description/name of each specific treatment intervention provided that match the CPT codes billed, including;
  - Treatment time for each modality or procedure performed
  - Parameters of any modality or procedure, (e.g., voltage/amperage, pad/electrode placement, area of treatment, types of exercises/activities, and intended goal of each therapy)
- The patient's response to each service and to the entire treatment session;
- Any progress toward the goals in objective, measurable terms using consistent and comparable methods;
- Any changes to the plan of care;
- Recommendations for follow-up visit(s);
- Signature/electronic identifier, name and credentials of the treating clinician.

7.3 Discharge/Discontinuation of Intervention

The occupational therapist discharges the patient from occupational therapy services when the anticipated goals or expected outcomes for the patient have been achieved. The occupational therapist discontinues intervention when the patient is unable to continue to progress toward goals or when the occupational therapist determines that the patient will no longer benefit from occupational therapy.

The occupational therapy discharge documentation includes:

- The status of the patient at discharge and the goals and outcomes attained
- Appropriate date and authentication by the occupational therapist who performed the discharge
- When a patient is discharged prior to attainment of goals and outcomes, the status of the patient and the rationale for discontinuation
- Initial, subsequent, and final FOMs scores
- Proposed self-care recommendations, if applicable
- Referrals to other health care practitioners/referring physicians as appropriate
- If the patient self- discharges, documentation of final status and if known, the reason for discontinuation of services.

7.4 Duplicated / Insufficient Information

(1) Entries in the medical record should be contemporaneous, individualized, appropriately comprehensive, and made in a chronological, systematic, and organized manner. Duplicated/nearly duplicated medical records (a.k.a. cloned records) are not acceptable. It is not clinically reasonable or physiologically feasible that a patient's condition will be identical on multiple encounters. (Should the finding be identical for encounters, it would be expected that treatment would end because patient is not making progress toward current goals.)

This includes, but not limited to:

- duplication of information from one treatment session to another (for the same or different patient[s]);
- duplication of information from one evaluation to another (for the same or different patient[s]).

Duplicated medical records do not meet professional standards of medical record keeping and may result in an adverse determination (partial approval or denial) of those services.

(2) The use of a system of record keeping that does not provide sufficient information (e.g., checking boxes, circling items from lists, arrows, travel cards with only dates of visit and listings). These types of medical record keeping may result in an adverse determination (partial approval or denial) of those services.

Effective and appropriate records keeping that meet professional standards of medical record keeping document with adequate detail a proper assessment of the patient's status, the nature and severity of his/her complaint(s) or condition(s), and/or other relevant clinical information (e.g., history, parameters of each therapy performed, objective findings, progress towards treatment goals, response to care, prognosis).

7.5 Centers for Medicare and Medicaid Services (CMS)

For Medicare and Medicaid services, medical records keeping must follow and be in accordance with Medicare and any additional state Medicaid required documentation guidelines.

8. CLINICAL REVIEW PROCESS

Medical necessity evaluations require approaching the clinical data and scientific evidence from a global perspective and synthesizing the various elements into a congruent picture of the patient's condition and need for skilled treatment intervention. Clinical review decisions made by the clinical quality evaluators are based upon the information provided by the treating practitioner in the submitted documentation and other related findings and information. Failure to appropriately document pertinent clinical information may result in

adverse determinations (partial approval or denial) of those services. Therefore, thorough documentation of all clinical information that established the diagnosis/diagnoses and supports the intended treatment is essential.

8.1 Definition of Key Terminology used in Clinical Reviews

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 MTB. (Elective/convenience services may not be covered through specific client or ASH benefits.)

Minimal Clinically Important Difference (MCID)

The MCID is the minimal amount of change in a score of a valid outcome assessment tool that indicates an actual improvement in the patient's function or pain. Actual significance of outcome assessment tool findings requires correlation with the overall clinical presentation, including updated subjective and objective examination/evaluation findings.

Maximum Therapeutic Benefit (MTB)

MTB is the patient's health status when the application of skilled therapeutic services has achieved its full potential (which may or may not be the complete resolution of the patient's condition.) At the point of MTB, continuation of the same or similar 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 decreasing the use of passive care (modalities, massage etc.) and increasing 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.

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 or may not be covered under specific clients or through ASH benefits.)

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.

8.2 Clinical Quality Evaluation

The goal of the clinical quality evaluators during the review and decision-making process is to approve, as appropriate, those clinical services necessary to return the patient to pre-clinical/pre-morbid health status or stabilize a chronic condition, as supported by the documentation presented. The clinical quality evaluator is to evaluate if the documentation and other clinical information presented by the treating provider has appropriately substantiated the patient's condition and appropriately justifies the treatment plan that is presented.

Approval
ASH clinical quality evaluators have the responsibility to approve appropriate care for all services that are medically necessary. The clinical quality evaluators assess the clinical data supplied by the practitioner in order to determine whether submitted services and/or the initiation or continuation of care has been documented as medically necessary. The practitioner is accountable to document the medical necessity of all services

submitted/provided. It is the responsibility of the peer clinical quality evaluator to evaluate the documentation in accordance with their training, understanding of practice parameters, and review criteria adopted by ASH through its clinical committees.

The following items influence 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.

Partial Approval

Occurs when only a portion of the submitted services are determined to be medically necessary services. The partial approval may refer to a decrease in treatment frequency, treatment duration, number of Durable Medical Equipment (DME)/supplies/appliances, number of therapies, or other services from the original amount/length submitted for review. This decision may be due to any number of reasons, such as:

- the practitioner's documentation of the history and exam findings are inconsistent with the clinical conclusion(s)
- the treatment dosage (frequency/duration) submitted for review is not supported by the underlying diagnostic or clinical features
- the need to initiate only a limited episode of care in order to monitor the patient's response to care

Additional services may be submitted and reviewed for evaluation of the patient's response to the initial trial of care. If the practitioner or patient disagrees with the partial approval of services, they contact the clinical quality evaluator listed on their response form to discuss the case, submit additional documentation through the Reopen process, or submit additional documentation to appeal the decision through the Provider Appeals and Member Grievances process.

Non-approval / Denial

Occurs when none of the services submitted for review are determined to be medically necessary services. The most common causes for a non-approval/denial of all services are administrative or contractual in nature (e.g., ineligibility, reached plan benefit limits, non-coverage). Clinically, it is appropriate to deny continued/ongoing care if the patient's

condition(s) are not, or are no longer, responding favorably to the services being rendered by the treating practitioner, or the patient has reached maximum therapeutic benefit.

Additional / Continued Care

Approval of additional treatment/services requires submission of additional information, including the patient's response to care and updated clinical findings. In cases where an additional course of care is submitted, the decision to approve additional services will be based upon the following criteria:

- The patient has made clinically significant progress under the initial treatment plan/program based on a reliable and valid outcome tool or updated subjective and objective examination findings.
- Additional clinically significant progress can be reasonably expected by continued treatment (the patient has not reached MTB or maximum medical improvement).
- There is no indication that immediate care/evaluation is required by other health care professionals.

Any exacerbation or flare-up of the condition that contributes to the need for additional treatment/services must be clearly documented.

Ancillary diagnostic procedures should be selected based on clinical history and examination findings that suggest the necessity to rule out underlying pathology or to confirm a diagnosis that cannot be verified through less invasive methods.

- Information is expected to directly impact the treatment/services and course of care.
- The benefit of the procedure outweighs the risk to the patient's health (short and long term).
- The procedure is sensitive and specific for the condition being evaluated (e.g., an appropriate procedure is utilized to evaluate for pathology).

The clinical information that the clinical quality evaluator expects to see when evaluating the documentation in support of the medical necessity of submitted treatment/services should be commensurate with the nature and severity of the presenting complaint(s) and scope of the practitioner of services and may include but is not limited to:

- History
- Physical Examination/Evaluation
- Documented Treatment Plan and Goals
- Estimated time of Discharge

In general, the initiation of care is warranted if there are no contraindications to prescribed care, there is reasonable evidence to suggest the efficacy of the prescribed intervention, and the intervention is within the scope of services permitted by State or Federal law. The treatment submission for a disorder is typically structured in time-limited increments

depending on clinical presentation. Dosage (frequency and duration of service) should be appropriately correlated with clinical findings, potential complications/barriers to recovery and clinical evidence. When the practitioner discovers that a patient is nonresponsive to the applied interventions within a reasonable time frame, re-assessment and treatment modification should be implemented and documented. If the patient's condition(s) worsen, the practitioner should take immediate and appropriate action to discontinue or modify care and/or make an appropriate healthcare referral.

Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary., If a patient's recovery can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.

8.3 Critical Factors during Clinical Reviews

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. Clinical quality evaluators 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, and frequency of encounters that the average); these patients require a higher frequency; but may require short-term trials of care initially to assess patient response to care.
- Less severe symptomatology, exam findings and/or functional deficits usually require less care (e.g., shorter duration, fewer services per encounter, and frequency of encounters that the average); overall 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 the factors clinical quality evaluators consider when verifying the medical necessity of rehabilitative services for musculoskeletal conditions and pain disorders.

8.3.1 General Factors

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

- Red Flags
- Yellow Flags (Psychosocial Factors)
- 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 that are 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 clinical quality evaluator 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 clinical quality evaluator 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. 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 that is worse at night or not relieved by any position.
- Suspicion of cerebrovascular compromise.
- Symptom's 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.
- 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.
- Signs and symptoms that do not fit the normal pattern and are not resolving.

Assessment of Yellow Flags

When yellow flags are present, clinicians need to be vigilant for deviations from the normal course of illness and recovery. 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. The clinical quality evaluator may recommend returning the patient back to the referring healthcare practitioner or referring the patient to other health care practitioner/specialist as appropriate.

Assessment of Historical Information

The following factors are assessed in review and determination if the services are medically necessary:

- The mechanism of onset and date of onset are congruent with the stated condition's etiology.
- The patient's past medical history and response to care do not pose contraindication(s) for the services submitted for review.
- The patient's past medical history of pertinent related and unrelated conditions does not pose contraindication(s) for the services submitted for review.
- The patient's complaint(s) have component(s) that are likely to respond favorably to services submitted for review.
- Provocative and palliative factors identified on examination indicate the presence of a musculoskeletal condition as expected per diagnosis(es) or complaints, or as consistent with other type of diagnosis(es).
- The patient's severity of limitations to activities of daily living (ADLs) are appropriate and commensurate for the presence of the condition(s) or disorder(s).
- The quality, radiation, severity, and timing of pain are congruent with the documented condition(s) or disorder(s).
- The patient's past medical history of having the same or similar condition(s) indicates a favorable response to care.
- The absence or presence of co-morbid condition(s) may or may not present absolute or relative contraindications to care.

Assessment of Examination Findings

- The exam procedures, level of complexity, and components are appropriate for the patient's complaint(s) and historical findings.
- Objective palpatory, orthopedic, neurologic, and other physical examination findings are current, clearly defined, qualified, and quantified, including the nature, extent, severity, character, professional interpretation, and significance of the finding(s) in relation to the patient's complaint(s) and differential diagnosis(es).
- Exam findings provide evidence justifying the condition(s) is/are likely to respond favorably to services submitted for review.

- Exam findings provide a reasonable and reliable basis for the stated diagnosis(es).
- Exam findings provide a reasonable and reliable basis for treatment planning; accounting for variables such as age, sex, physical condition, occupational and recreational activities, co-morbid conditions, etc.
- The patient's progress is being appropriately monitored each visit (as noted within daily chart notes and during periodic re-exams) to ensure that acceptable clinical progress is realized.

Assessment of Treatment / Treatment Planning

- Treatment dosage (frequency and duration of service) is appropriately correlated with the nature and severity of the subjective complaints, potential complications/barriers to recovery, and objective clinical evidence.
- 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 an Occupational Therapist. Therefore, if the continuation of a patient's care can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.
- The use of passive modalities in the treatment of subacute or chronic conditions beyond the acute inflammatory response phase requires documentation of the anticipated benefit and condition-specific rationale in order to be considered medically necessary.
- The treatment plan includes the use of therapeutic procedures to address functional deficits and ADL restrictions.
- The set therapeutic goals are functionally oriented, realistic, measurable, and evidence based.
- The proposed date of release/discharge from treatment is clearly defined.
- The treatment/therapies are appropriately correlated with the nature and severity of the patient's condition(s) and set treatment goals.
- Functional Outcome Measures (FOM) demonstrate minimal clinically important difference (MCID) from baseline results through periodic reevaluations during the course of care. This is important in order to determine the need for continued care, the appropriate frequency of visits, estimated date of release from care, and if a change in the treatment plan or a referral to an appropriate health care practitioners/specialist is indicated.
- Home care, self-care, and active-care instructions are documented.
- Durable Medical Equipment (DME), supplies, appliances, and supports are provided when medically necessary and appropriately correlated with clinical findings and clinical evidence.

Assessment of Diagnostic Imaging / Special Studies

- Laboratory tests are performed only when medically necessary to improve diagnostic accuracy and treatment planning. Abnormal values are professionally interpreted as they relate to the patient's complaint(s) or to unrelated co-morbid conditions that may or may not impact the patient's prognosis and proposed treatment.
- 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)* clinical practice guideline).
- 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 deficit. For more information, see the *Electrodiagnostic Testing (CPG 129-S)* clinical practice guideline.
- Imaging or special studies' findings are appropriate given the nature and severity of the patient's condition(s) and the findings obtained are likely to influence the basis for the proposed treatment.

8.3.2 Factors that Influence Adverse Determinations of Clinical Services (Partial Approvals/Denials)

Factors that influence adverse determinations of clinical services may include but are not limited to these specific considerations and other guidelines and factors identified elsewhere in this policy.: Topics/factors covered elsewhere in this guideline are also applicable in this section and may result in an adverse determination on medical necessity review. To avoid redundancy, many of those factors have not been listed below.

Additional Factors Considered in Determination of Medical Necessity
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 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

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 interpretated, 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 clinical quality evaluator 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
    - inappropriate use of passive modalities in the plan of care
    - 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 redundant and not reasonable or medically necessary

- Home care, self-care, and/or 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:
    - preventive care
    - elective/convenience/wellness care
    - back school
    - 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, 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 above)
- There are historical, subjective, and/or objective findings which present as contraindications for the plan of care

8.3.3 Referral / Coordination of Services

When a potential health and safety issue is identified, the clinical quality evaluator 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 don't 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.

The Clinical Policy is reviewed and approved by the ASH Clinical Quality committees that are comprised of contracted network practitioners including practitioners of the same clinical discipline as the treating providers for whom compliance with the practices articulated in this this document is required. Guidelines are updated at least annually, or as new information is identified that result in material changes to one or more of these policies.

9. LITERATURE REVIEW

9.1 Occupational Therapy for Conditions Considered Unproven

There is a limited amount of evidence regarding individual occupational therapy interventions for specific conditions. There are several Cochrane systematic reviews and other reviews that have been published regarding occupational therapy for various conditions (Steultjens, et al., 2004; Steultjens et al., 2005; Legg et al., 2006; Dixon et al., 2007; Hoffman et al., 2011; Hoare et al., 2021; Quinn et al., 2021; Legg et al., 2021; García-Pérez et al., 2021; Fields and Smallfield, 2022; Cunningham et al., 2022; Wood et al., 2022). The reviews in general found that that there is improvement seen with occupational therapy however, evidence with respect to specific interventions is limited. Passive modalities, such as ultrasound, electric stimulation, traction, laser, and hot and cold packs,

are often used in combination with manual therapies and exercise despite insufficient and/or inconclusive evidence for many conditions. Often methodologic flaws and heterogeneity of studies result in an inability to draw confirmatory conclusions.

9.2 Specific Occupational Therapy Treatments Considered Unproven

Constraint-Induced Movement Therapy (CIMT)

Constraint-induced movement therapy (CIMT) is a multi-faceted intervention that has been proposed for neurological conditions that involve hemiparesis. CIMT is also referred to as constraint-induced therapy or forced use therapy and is primarily provided by physical therapists and occupational therapists. Several variations exist based on method and length of restraint, and type and duration of therapy (e.g., environment and provider). The therapy involves constraining the unaffected arm or hand with a sling, glove or mitt. CIMT typically involves intensive individualized therapy with up to six–eight hours of therapy provided per day. However, other forms of modified CIMT have been developed with less therapy provided, but longer periods of restraint (Wolf, 2007). Veterans Affairs/Dept of Defense (VA/DoD) published guidelines that have also been endorsed by American Heart Association/American Stroke Association (AHA/ASA)—Clinical Practice Guideline for the Management of Adult Stroke Rehabilitation Care (Bates, et al., 2005). The guidelines note that, "Use of constraint-induced therapy should be considered for a select group of patients—that is, patients with 20 degrees of wrist extension and 10 degrees of finger extension, who have no sensory and cognitive deficits." Indicating a recommendation that the intervention may be considered). The Royal College of Physicians/Intercollegiate Stroke Working Party (United Kingdom) and the Ottawa Panel (2006) agree with these recommendations.

CIMT has demonstrated inconsistent effectiveness for treatment of patients post-stroke (Abdullahi et al., 2020; Pulman et al., 2013; McIntyre et al., 2012; Corbetta et al., 2010; Sirtori et al., 2009; Abdullahi et al., 2021a; Abdullahi et al., 2021b; Alaca and Ocal, 2022). Future randomized controlled trials need to have accurate characteristics in terms of methodological quality, larger samples, longer follow up, reliable and relevant measure and report of adverse events. Some evidence demonstrates that modified CIMT could reduce the level of disability, improve the ability to use the paretic upper extremity, and enhance spontaneity during movement time, but evidence is still limited about the effectiveness of modified CIMT in kinematic analysis (Pollack et al., 2014; Shi et al., 2011). Research suggests that modified CIMT and intensive CIMT produce similar results (Peurala et al., 2012).

CIMT has also been used for the treatment of children with cerebral palsy (CP). Research is not conclusive with regards to the effectiveness of CIMT for this population; however there appears to be modest evidence to support its use in a modified format (Novak et al., 2020; Taub et al., 2004; Sakzewski et al., 2009; Eliasson et al., 2005; Hoare et al., 2007; Chen et al., 2014; Chiu and Ada, 2016; Eliasson et al., 2014, Hoare et al., 2019; Martínez-

Costa Montero et al., 2020; Ramey et al., 2021; Walker et al., 2022; Dionisio and Terrill, 2022; Jackman et al., 2022; Baker et al., 2022). Further research using adequately powered RCTs [randomized controlled trials], rigorous methodology and valid, reliable outcome measures is essential to provide higher level support of the effectiveness of CIMT for children with hemiplegic cerebral palsy.

Intensive Model of Therapy (IMOT) Programs

Refer to *Intensive Model of Therapy (CPG 286 – S)* clinical practice guideline for more information.

Dry Hydrotherapy

Dry hydrotherapy, also referred to as aqua massage, water massage, or hydromassage, is a treatment that incorporates water with the intent of providing therapeutic massage. The treatment is generally provided in chiropractor or therapy offices. There are several dry hydrotherapy devices available that provide this treatment, including the following:

- Aqua Massage® (AMI Inc., Mystic, CT)
- AquaMED® (JTL Enterprises, Inc., Clearwater, FL)
- H2Omassage System™ (H2Omassage Systems, Winnipeg, MB, Canada)
- Hydrotherapy Tables (Sidmar Manufacturing, Inc., Princeton, MN)

Proponents of dry hydrotherapy maintain that it can be used in lieu of certain conventional physical medicine therapeutic modalities and procedures, such as heat packs, wet hydrotherapy, massage, and soft tissue manipulation. The assertions that have been made by manufacturers of this device at their websites have not yet been proven. No published studies or information regarding dry hydrotherapy devices or dry hydrotherapy treatment were identified in the peer-reviewed scientific literature. In the absence of peer- reviewed literature demonstrating the effectiveness of dry hydrotherapy and in the absence of comparison to currently accepted treatment modalities, no definitive conclusions can be drawn regarding the clinical benefits of this treatment.

Non-invasive Interactive Neurostimulation (e.g., InterX®)

Refer to *Non-invasive Interactive Neurostimulation (InterX®) (CPG 277 – S*) clinical practice guideline for more information.

Microcurrent Electrical Nerve Stimulation (MENS)

Refer to *Electric Stimulation for Pain, Swelling and Function in the Clinic Setting (CPG 272 – S)* clinical practice guideline for more information.

H-WAVE ®

Refer to *H-WAVE® Electrical Stimulation (CPG 269 – S)* clinical practice guideline for more information.

Equestrian Therapy (e.g., Hippotherapy)

Equestrian therapy, also known as hippotherapy, is proposed to offer a person with a disability a means of physical activity that aids in improving balance, posture, coordination, the development of a positive attitude and a sense of accomplishment. It is proposed for treatment of several conditions including autism spectrum disorders and cerebral palsy. There is insufficient published evidence regarding the effects of this therapy on individuals with impaired physical function resulting from illness, injury, congenital defect or surgery (Bronson et al., 2010; Lee et al., 2014; O'Haire et al., 2014; De Guindos-Sanchez et al., 2020; Marquez et al., 2020; White et al., 2020; Santos de Assis et al., 2022; Pantera et al., 2022; Pérez-Gómez et al., 2022; Heussen and Häusler, 2022; Prieto et al., 2022). It is noted that most studies are limited by methodological weaknesses.

MEDEK Therapy

Refer *to MEDEK Therapy (CPG 276 – S)* clinical practice guideline for more information.

The Interactive Metronome Program

Interactive Metronome® (IM) is purported to be an assessment and training tool that measures and improves Neurotiming, or the synchronization of neural impulses within key brain networks for cognitive, communicative, sensory and motor performance. It is designed to improve processing speed, focus, and coordination. Patients wear headphones and match a beat using a hand or foot sensor along with visual and auditory feedback. The IM program has been promoted as a treatment for children with attention-deficit hyperactivity disorder (ADHD) and for other special needs children to increase concentration, focus, and coordination. It has also been promoted to improve athletic performance, to assess and improve academic performance of normal children, and to improve children's performance in the arts (e.g., dance, music, theater, creative arts). Additionally, it has been implemented as part of a therapy program for patients with balance disorders, cerebrovascular accident, limb amputation, multiple sclerosis, Parkinson's disease, and traumatic brain injury. However, based on peer-reviewed literature, evidence is insufficient to support effectiveness of the IM program. Well-designed clinical studies are needed to determine the effectiveness of the IM program and whether a clinically significant improvement is achieved.

Taping/Elastic Therapeutic Tape (e.g., Kinesio™ Tape, Spidertech™ Tape)

Refer to *Strapping and Taping (CPG 143 – S)* clinical practice guideline for more information.

Dry Needling

Refer to *Dry Needling (CPG 178 – S)* clinical practice guideline for more information.

Laser Therapy (LT)

Refer to *Laser Therapy (LT) (CPG 30 – S)* clinical practice guideline for more information.

10. CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Covered When Medically Necessary

CPT® Code	CPT® Code Description
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

CPT® Code	CPT® Code Description
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.

CPT® Code	CPT® Code Description
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and a clinical decision-making is of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

HCPCS Code	HCPCS Code Description
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective therapy maintenance program, each 15 minutes
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)
S9129	Occupational therapy, in the home, per diem

Training in Nature/Not Medically Necessary/Not Covered

CPT® Code	CPT® Code Description
97169	Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family

CPT® Code	CPT® Code Description
97170	Athletic training evaluation, moderate complexity, requiring these components: A medical history and physical activity profile with 1-2 comorbidities that affect physical activity. An examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97171	Athletic training evaluation, high complexity, requiring these components: A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; Clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97172	Re-evaluation of athletic training established plan of care requiring these components: An assessment of patient's current functional status when there is a documented change, and A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)

1

HCPCS Code	HCPCS Code Description
S8990	Physical or manipulative therapy performed for maintenance rather than restoration
S9117	Back school, per visit

Unproven and not covered when used to report constraint-induced movement therapy or dry hydrotherapy/aqua massage/hydromassage, equestrian therapy (e.g., hippotherapy), elastic therapeutic tape/taping, low-level laser:

HCPCS Code	HCPCS Code Description
S8940	Equestrian/hippotherapy, per session
S8948	Application of a modality (requiring constant provider attendance) to one or more areas, low-level laser; each 15 minutes

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