

1 **Clinical Practice Guideline: Athletic Training Medical Policy/Guideline**

2

3 **Date of Implementation: June 19, 2014**

4

5 **Product: Specialty**

6

7

Related Policies:

CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care

CPG 30: Laser Therapy (LT)

CPG 83: Axial/Spinal Decompression Therapy

CPG 110: Medical Record Maintenance and Documentation Practices

CPG 111: 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

CPG 133: Techniques and Procedures Not Widely Supported as Evidence-Based

CPG 143: Strapping and Taping

CPG 144: Prosthetic Training and Evaluation

CPG 146: Range of Motion Testing

CPG 148: Wheelchair Management

CPG 152: Orthotic Training and Evaluation

CPG 178: Dry Needling

CPG 269: H-Wave[®] Electrical Stimulation

CPG 270: Cognitive Rehabilitation

CPG 272: Electric Stimulation for Pain, Swelling and Function in the Clinic Setting

CPG 273: Superficial Heat and Cold

CPG 274: Deep Heating Modalities (Therapeutic Ultrasound and Diathermy)

CPG 275: Mechanical Traction (Provided in a Clinical Setting)

CPG 277: Non-invasive Interactive Neurostimulation (InterX[®])

CPG 295: Physical Performance Testing or Measurement

CPG 183 Revision 11 - S

Athletic Training Medical Policy/Guideline

Revised - August 15, 2023

To CHSO for review and approval 08/15/2023

CHSO reviewed and approved 08/15/2023

To CQT for informational review 09/11/2023

CQT reviewed as informational 09/11/2023

To QIC for informational review 10/03/2023

QIC reviewed as informational 10/03/2023

To QOC for review and adoption 10/19/2023

QOC reviewed and adopted 10/19/2023

TABLE OF CONTENTS
(CTRL+Click on Section Heading to Follow Link)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

1. PROVIDERS OF ATHLETIC TRAINING SERVICES 3

2. REHABILITATIVE ATHLETIC TRAINING SERVICES..... 5

3. MAINTENANCE ATHLETIC TRAINING SERVICES 8

4. REDUNDANT THERAPEUTIC EFFECTS AND DUPLICATIVE REHABILITATIVE SERVICES BY SAME OR DIFFERENT HEALTHCARE PRACTITIONERS/SPECIALTIES..... 8

5. THERAPEUTIC MODALITIES AND PROCEDURES 9

 5.1 Passive Care and Active Care.....10

 5.2 Treatment Interventions.....11

 5.3 Contraindications to Therapeutic Modalities and Procedures16

6. CLINICAL DOCUMENTATION20

 6.1 Evaluation and Re-evaluations20

 6.2 Treatment Sessions22

 6.3 Discharge/Discontinuation of Intervention.....24

 6.4 Duplicated / Insufficient Information24

 6.5 Centers For Medicare and Medicaid Services (CMS)25

7. CLINICAL REVIEW PROCESS25

 7.1 Definition of Key Terminology used in Clinical Reviews25

 7.2 Clinical Quality Evaluation27

 7.3 Critical Factors during Clinical Reviews29

 7.3.1 General Factors.....30

 7.3.2 Factors that Influence Adverse Determinations of Clinical Services (Partial Approvals/Denials)35

 7.3.3 Referral / Coordination of Services40

8. LITERATURE REVIEW41

 8.1 Rehabilitation for Conditions Considered Unproven41

 8.2 Specific Treatments Considered Unproven41

1 **DESCRIPTION**

2 This document addresses Athletic Training Services which may be delivered by an Athletic
3 Trainer acting within the scope of a professional license. This document also addresses the
4 processes associated with Medical Necessity Determinations performed by American
5 Specialty Health (ASH) Clinical Quality Evaluators (CQEs) on services submitted for
6 review.

7
8 The availability of coverage for rehabilitative and/or habilitative services will vary by
9 benefit design as well as by State and Federal regulatory requirements. Benefit plans may
10 include a maximum allowable rehabilitation benefit, either in duration of treatment or in
11 number of visits or in the conditions covered or type of services covered. When the
12 maximum allowable benefit is exhausted or if the condition or service are not covered,
13 coverage will no longer be provided even if the medical necessity criteria described below
14 are met.

15
16 **GUIDELINES**

17 **1. PROVIDERS OF ATHLETIC TRAINING SERVICES**

18 Covered, medically necessary rehabilitative or habilitative services must be delivered by a
19 qualified Athletic Trainer (AT) acting within the scope of their license as regulated by the
20 Federal and State governments.

21
22 As stated in the *Athletic Training Services: An Overview of Skills and Services Performed*
23 *by Certified Athletic Trainers (2010)* document, athletic trainers are health care
24 professionals who collaborate with physicians to optimize patient and client activity and
25 participation in athletics, work and life. According to this document, the practice of athletic
26 training encompasses the prevention, examination and diagnosis, treatment, and
27 rehabilitation of emergent (not applicable to program/benefit settings), acute, subacute, and
28 chronic musculoskeletal conditions and certain medical conditions in order to minimize
29 subsequent impairments, functional limitations, disability, and societal limitations.

30
31 Athletic trainers' work settings can include high schools, colleges, universities, professional
32 sports teams, hospitals, rehabilitation clinics, physicians' offices, corporate and industrial
33 institutions, the military, and the performing arts. Regardless of their practice setting,
34 athletic trainers practice athletic training according to their education and state practice act.

35
36 The outpatient rehabilitation clinic is a specialized setting within the athletic training field
37 and is the setting that applies to this program. Athletic trainers working in this setting still
38 work under their state license and scope of practice. In this setting, athletic trainers:

- 39
- 40 • Perform evaluations and special tests – depending on state practice act
 - 41 • Educate patients and answering questions
 - Implement industrial/back to work programs

- 1 • Perform ergonomic assessments
- 2 • Do DME/brace fitting
- 3 • Perform therapeutic exercise and modality application
- 4 • Administer gait training
- 5 • Instruct in home exercise programs

6
7 The “non-clinical” setting, such as an athletic training room or at an athletic event is not
8 within the scope of this program.

9
10 The scope of this athletic training policy does not indicate benefit coverage but rather
11 describes services provided by athletic trainers in the clinical setting. An athletic trainer
12 shall practice only in those areas in which the athletic trainer is competent due to training or
13 experience that can be substantiated by records or other evidence if necessary.

14
15 Athletic Trainers provide services to patients to improve, adapt or restore functions that
16 have been impaired or permanently lost as a result of acute, subacute, and chronic
17 neuromusculoskeletal conditions and/or certain medical conditions. Medically necessary
18 athletic training services must relate to a written treatment plan of care and be of a level of
19 complexity that requires the judgment, knowledge and skills of an Athletic Trainer to
20 perform and/or supervise the services.

21
22 A service is not considered a skilled athletic training service merely because it is furnished
23 by an AT. If a service can be self-administered or safely and effectively furnished by an
24 unskilled person, without the direct or general supervision, as applicable, of an AT, the
25 service cannot be regarded as a skilled rehabilitation service even though an AT actually
26 furnishes the service. Similarly, the unavailability of a competent person to provide a non-
27 skilled service, notwithstanding the importance of the service to the patient, does not make
28 it a skilled service when an AT furnishes the service.

29
30 Services that do not require the professional skills of an AT to perform are not medically
31 necessary, even if they are performed by the AT, physician or NPP. Therefore, if a patient’s
32 rehabilitation can proceed safely and effectively through a home exercise program, self-
33 management program, restorative nursing program or caregiver assisted program, athletic
34 training services are not indicated or medically necessary. Athletic training is used for
35 rehabilitation. Rehabilitative services are intended to improve, adapt or restore functions
36 which have been impaired or permanently lost as a result of illness, injury, loss of a body
37 part, or congenital abnormality involving goals an individual can reach in a reasonable
38 period of time. If no improvement is documented after two weeks of treatment, an
39 alternative treatment plan should be attempted. Treatment is no longer medically necessary
40 when the individual stops progressing toward established goals.

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

10 **2. REHABILITATIVE ATHLETIC TRAINING SERVICES**

11 **Medically Necessary:**

12 (1) Rehabilitative athletic training (AT) services to improve, adapt or restore functions
 13 which have been impaired or permanently lost as a result of acute, subacute, and
 14 chronic neuromusculoskeletal conditions and certain medical conditions are considered
 15 medically necessary when ALL the following criteria are met:

- 16 1. The services are delivered by a qualified provider of athletic training services (i.e.,
 17 appropriately trained and licensed by the state to perform athletic training services);
 18 and
- 19 2. Rehabilitative therapy occurs when the judgment, knowledge, and skills of a
 20 qualified provider of athletic training services (as defined by the scope of practice
 21 for athletic trainers in each state) are necessary to safely and effectively furnish a
 22 recognized service due to the complexity and sophistication of the plan of care and
 23 the medical condition of the individual, with the goal of improvement of an
 24 impairment or functional limitation.
- 25 3. The patient's condition has the potential to improve or is improving in response to
 26 rehabilitation services, maximum improvement is yet to be attained; and there is an
 27 expectation that the anticipated improvement is attainable in a reasonable and
 28 predictable period of time; and
- 29 4. Improvement or restoration of function could not be reasonably expected as the
 30 individual gradually resumes normal activities without the provision of skilled
 31 rehabilitative services; and
- 32 5. The documentation objectively verifies progressive functional improvement over
 33 specific time frames and clinically justifies the initiation of continuation of
 34 rehabilitative services; and

35
 36 *Reasonable and predictable period of time: The specific time frames for which one
 37 would expect practical functional improvement is dependent on various factors
 38 including whether the services are Rehabilitative services. A reasonable trial of care
 39 for rehabilitative services to determine the patient's potential for improvement in or
 40 restoration of function is influenced by the diagnosis; clinical evaluation findings; stage

1 of the condition (acute, sub-acute, chronic); severity of the condition; and patient-
 2 specific elements (age, gender, past and current medical history, family history, and
 3 any relevant psychosocial factors).

- 4
 5 (2) An athletic trainer evaluation is considered medically necessary for the assessment of
 6 a physical impairment.

7
 8 **Not Medically Necessary:**

- 9 (1) Rehabilitative AT services are considered not medically necessary if any of the
 10 following is determined:

- 11 1. Rehabilitative services are NOT intended to improve, adapt or restore functions
 12 which have been impaired or permanently lost as a result of acute, subacute, and
 13 chronic musculoskeletal conditions and certain medical conditions.
- 14 2. Improvement or restoration of function could reasonably be expected to improve
 15 as the individual gradually resumes normal activities without the provision of
 16 skilled AT services. For example:
- 17 ○ A patient suffers a transient and easily reversible loss or reduction in function
 18 could reasonably be expected to improve spontaneously as the patient gradually
 19 resumes normal activities.
 - 20 ○ A fully functional patient who develops weakness from a brief period of bed
 21 rest.
- 22 3. AT services do not require the skills of a qualified provider of AT services.
 23 Examples include but are not limited to:
- 24 ○ General exercises (basic aerobic, strength, flexibility or aquatic programs) to
 25 promote overall fitness/conditioning;
 - 26 ○ Services for the purpose of enhancing athletic or recreational sports
 27 performance or for return to sport after injury or surgery;
 - 28 ○ Massages and whirlpools for relaxation, basic flexibility or exercise programs,
 29 swimming and routine water aerobics programs; and
 - 30 ○ General public education/instruction sessions; or
 - 31 ○ Repetitive gait or other activities that an individual can practice independently
 32 or with a caregiver or routine re-evaluations.
 - 33 ○ Activities that require only routine supervision and NOT the skilled services
 34 of an athletic trainer.
 - 35 ○ When a home exercise program is sufficient and can be utilized to continue
 36 therapy (examples of exceptions include but would not be limited to the
 37 following: if patient has poor exercise technique that requires cueing and
 38 feedback, lack of support at home if necessary for exercise program
 39 completion, and/or cognitive impairment that doesn't allow the patient to
 40 complete the exercise program).

- 1 4. The expectation does **not** exist that the service(s) will result in a clinically
 2 significant improvement in the level of functioning within a reasonable and
 3 predictable period of time (up to 4 weeks).
 - 4 ○ If function could reasonably be expected to improve as the individual
 5 gradually resumes normal activities, then the service is considered **not**
 6 medically necessary.
 - 7 ○ The patient’s condition does not have the potential to improve or is not
 8 improving in response to therapy; or would be insignificant relative to the
 9 extent and duration of therapy required; and there is an expectation that
 10 further improvement is NOT attainable.
 - 11 ○ The documentation fails to objectively verify functional progress over a
 12 reasonable period of time (up to 4 weeks).
 - 13 ○ The patient has reached maximum therapeutic benefit.
- 14 5. A passive modality is **not** preparatory to other skilled treatment procedures or is
 15 not necessary in order to provide other skilled treatment procedures safely and
 16 effectively.
- 17 6. A passive modality has insufficient published evidence to support a clinically
 18 meaningful physiologic effect on the target tissue or improve the potential for a
 19 positive response to care for the condition being treated.
- 20 7. Reevaluations or assessments of a patient’s status that are not separate and distinct
 21 services from those work components included within athletic training services
 22 provided.
- 23 8. Reevaluations or assessments of a patient’s status that are not necessary to continue
 24 a course of therapy nor related to a new condition or exacerbation for which the
 25 reevaluation will likely result in a change in the treatment plan.
- 26 9. The treatments/services are not supported by and are not performed in accordance
 27 with peer-reviewed literature as documented in applicable ASH CPGs or other
 28 literature accepted by ASH Clinical Quality committees.
- 29
- 30 (2) The following treatments/programs are **not** considered medically necessary because
 31 they are nonmedical, non-rehabilitative, educational, or training in nature. In addition,
 32 these treatments/programs are specifically excluded under many benefit plans:
 - 33 1. Back school
 - 34 2. Vocational rehabilitation programs and any program with the primary goal of
 35 returning an individual to work
 - 36 3. Work hardening programs
 - 37 4. Health and wellness interventions.
- 38
- 39 (3) Rehabilitation for the treatment of any of the following conditions is considered
 40 unproven:
 - 41 1. Scoliosis curvature correction (e.g., Schroth Method)

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

1. Dry hydrotherapy/aquamassage/hydromassage
2. Non-invasive Interactive Neurostimulation (e.g., InterX®) [Non-invasive Interactive Neurostimulation (InterX®) (CPG 277 – S)]
3. Microcurrent Electrical Nerve Stimulation (MENS)
4. H-WAVE ® [H-WAVE® Electrical Stimulation (CPG 269 – S)]
5. Elastic therapeutic tape/taping (e.g., Kinesio™ tape, KT TAPE/KT TAPE PRO™, Spidertech™ tape) [Strapping and Taping (CPG 143 – S)]
6. Dry Needling [Dry Needling (CPG 178 – S)]
7. Laser therapy [Laser Therapy (LT) (CPG 30 – S)]
8. Vertebral axial decompression therapy and devices (e.g., VAX-D, DRX, DRX2000, DRX3000, DRX5000, DRX9000, DRS, Dynapro™ DX2, Accu-SPINA™ System, IDD Therapy® [Intervertebral Differential Dynamics Therapy], Tru Tac 401, Lordex Power Traction device, Spinerx LDM) [Axial/Spinal Decompression Therapy (CPG 83 – S)]

3. MAINTENANCE ATHLETIC TRAINING SERVICES

A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. A maintenance program may be necessary as an adjunct to a home therapy program. However, maintenance care for persons whose condition is neither regressing nor improving is typically not considered medically necessary. Services provided by athletic trainers for asymptomatic persons or in persons without an identifiable clinical condition are not considered medically necessary.

4. REDUNDANT THERAPEUTIC EFFECTS AND DUPLICATIVE REHABILITATIVE SERVICES

1. Redundant rehabilitative therapy services expected to achieve the same therapeutic goal are considered not medically necessary. For example:
 - 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 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 athletic training services and/or physical, occupational, or speech therapy, the practitioners should provide different treatments that reflect each discipline's unique perspective on the individual's

1 impairments and functional deficits and not duplicate the same treatment. They
 2 must also have separate evaluations, treatment plans, and goals. As an example,
 3 when individuals receive manual therapy services from an athletic trainer and
 4 physical therapist or chiropractor, the services must be documented as separate
 5 and distinct, performed on different body parts, and must be justified and non-
 6 duplicative.

8 **5. THERAPEUTIC MODALITIES AND PROCEDURES**

9 The CPT codebook defines a modality as "any physical agent applied to produce
 10 therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic,
 11 light, mechanical, or electric energy". Modalities may be supervised, which means that
 12 the application of the modality doesn't require direct one-on-one patient contact by
 13 the practitioner. This means that set-up and application of the modality needs to be
 14 supervised by a rehabilitation professional, but they do not need to perform the modality.
 15 Modalities may also involve constant attendance, which indicates that the modality
 16 requires direct one-on-one patient contact by the practitioner.

17
 18 Supervised modalities are untimed therapies. Untimed therapies are usually reported only
 19 once for each date of service regardless of the number of minutes spent providing this
 20 service or the number of body areas to which they were applied. Untimed services billed
 21 as more than one unit will require significant documentation to justify treatment greater
 22 than one session per day. Examples of supervised modalities include application of:

- 23 • Hot or cold packs
- 24 • Mechanical traction
- 25 • Unattended electrical stimulation (i.e., for pain relief)
- 26 • Vasopneumatic devices
- 27 • Whirlpool
- 28 • Paraffin bath
- 29 • Diathermy

30
 31 Modalities that require constant attendance, are timed and reported in 15-minute
 32 increments (one unit) regardless of the number of body areas to which they are applied.
 33 Examples of modalities that require constant attendance include:

- 34 • Contrast baths
- 35 • Ultrasound
- 36 • Attended electrical stimulation (i.e., NMES)
- 37 • Iontophoresis

38
 39 The CPT codebook defines therapeutic procedures as "A manner of effecting change
 40 through the application of clinical skills and/or services that attempt to improve function."

1 Except for Group Therapy (97150) and Work Hardening/Conditioning (97545-6),
 2 therapeutic procedures require direct (one-on-one) patient contact by the Athletic Trainer,
 3 are timed therapies, and must be reported in units of 15-minute increments. Only the actual
 4 time that the Athletic Trainer is directly working with the patient performing
 5 exercises/activities, instruction, or assessments is counted as treatment time. The time that
 6 the patient spends not being treated because of a need for rest or equipment set up is not
 7 considered treatment time. Any exercise/activity that does not require, or no longer
 8 requires, the skilled assessment and intervention of a health care practitioner is not
 9 considered a medically necessary therapeutic procedure. Exercises often can be taught to
 10 the patient or a caregiver as part of a home/self-care program. Examples of therapeutic
 11 procedures that require the Athletic Trainer to have direct (one-on-one) patient contact
 12 include:

- 13 • therapeutic exercises
- 14 • neuromuscular reeducation
- 15 • gait training
- 16 • manual therapy (e.g., soft tissue mobilization)
- 17 • therapeutic activities

19 **Documentation Requirements to Substantiate Medical Necessity of Therapeutic** 20 **Modalities and Procedures**

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

33 **5.1 Passive Care and Active Care**

34 Generally, passive modalities are used to manage the acute inflammatory response, pain,
 35 and/or muscle tightness or spasm in the early stages of musculoskeletal and related
 36 condition management. They are most effective during the acute phase of treatment. The
 37 use of passive modalities in the treatment of sub-acute or chronic conditions beyond the
 38 acute inflammatory response time frame is generally considered not medically necessary
 39 unless there is an exacerbation. Passive modalities are rarely beneficial alone and are most
 40 effective when performed as part of a comprehensive treatment approach. Some
 41 improvement with the use of passive modalities should be seen within three visits. If

1 passive therapy is not contributing to improvement, passive therapy should be
 2 discontinued, and other evidence supported interventions implemented. The use of passive
 3 modalities is generally considered not medically necessary unless they are preparatory and
 4 essential to the safe and effective delivery of other skilled treatment procedures (e.g.,
 5 therapeutic exercise training, etc.). Prolonged reliance on passive modalities is not
 6 supported by the clinical literature.

7
 8 A “passive therapy” is a procedure applied by a clinical practitioner without active
 9 engagement of or movement by the patient (e.g., ultrasound, hot packs).

10
 11 The selection of a passive modality should be based on an understanding of the known
 12 physiologic effects of the modality, contraindications, the stage of injury and/or tissue
 13 healing, anatomical location to be treated, patient specific conditions and the likelihood of
 14 the therapy to enhance recovery or facilitate treatment with manual and active therapeutic
 15 procedures. Use of more than two (2) modalities on each visit date is unusual and should
 16 be justified in the documentation.

17
 18 Transition from passive physiotherapy modalities to active treatment procedures should be
 19 timely and evidenced in the medical record, including instructions on self/home care.
 20 Active therapeutic procedures are typically started as swelling, pain, and inflammation are
 21 reduced. Active care elements include increasing range of motion, strengthening primary
 22 and secondary stabilizers of a given region, and increasing the endurance capability of the
 23 muscles. Care focuses on active participation of the patient in their exercise program. Gait
 24 training, muscle strengthening, and progressive resistive exercises are considered active
 25 procedures. Patients should progress from active procedures requiring the supervision of a
 26 skilled practitioner to a self-directed home activity program as soon as possible.

27 28 **5.2 Treatment Interventions**

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

33 34 **Hydrotherapy/Whirlpool/Hubbard Tank**

35 These modalities involve supervised use of agitated water in order to relieve muscle
 36 spasm, improve circulation, or cleanse wounds (e.g., skin conditions). More specifically,
 37 Hubbard tank involves a full-body immersion tank for treating severely burned,
 38 debilitated and/or neurologically impaired individuals.

1 **Fluidotherapy®**

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

10
 11 **Vasopneumatic Devices**

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

18
 19 **Hot/Cold Packs**

20 Hot packs increase blood flow, relieve pain and increase movement. Cold packs decrease
 21 blood flow to an area for pain and swelling reduction. Hot/cold packs are typically used
 22 in the acute phase of injury or in the acute phase of an exacerbation. They are considered
 23 medically necessary for painful musculoskeletal conditions and acute injury.

24
 25 **Paraffin Bath**

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

29
 30 **Mechanical Traction**

31 This device provides a mechanical pull on the spine (cervical or lumbar) to relieve pain,
 32 spasm, and nerve root compression. . Mechanical traction may be considered medically
 33 necessary only when there is no improvement after the application of other evidence-based
 34 therapeutic procedures to significantly improve symptoms for 3 weeks; the patient has
 35 signs of nerve root compression or radiculopathy; it is used in combination with other
 36 evidence-based treatments including therapeutic exercise with extension movements.
 37 Axial Decompression Therapy (aka Decompression Therapy or Spinal Decompression
 38 Therapy) are considered experimental and not medically necessary.

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 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

Iontophoresis is electric current 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 reduction 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

1 which has been lost or limited as a result of a disease or injury. Exercising performed by
 2 the patient within a clinic facility or other location (e.g., home; gym) without a physician
 3 or therapist present and supervising would be considered not medically necessary.

4 **Neuromuscular Re-education (NMR)**

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

20 **Aquatic Therapy**

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

29 **Gait Training**

30 This procedure involves teaching individuals with musculoskeletal disorders how to
 31 ambulate given their disability or to ambulate with an assistive device. Assessment of
 32 muscle function and joint position during ambulation is considered a necessary
 33 component of this procedure, including direct visual observation and may include
 34 video, various measurements, and progressive training in ambulation and stairs. Gait
 35 training is considered medically necessary for training individuals whose walking
 36 abilities have been impaired by muscular or skeletal abnormalities, surgery, or trauma.
 37 This also includes crutch/cane ambulation training and re-education.

39 **Therapeutic Massage**

40 Therapeutic Massage involves the application of fixed or movable pressure, holding and/or
 41 causing movement of or to the body, using primarily the hands and may be considered

1 medically necessary when performed to restore muscle function, reduce edema, improve
2 joint motion, or relieve muscle spasm caused by a specific condition or injury.

3 4 **Soft Tissue Mobilization**

5 Soft tissue mobilization techniques are more specific in nature and include, but are not
6 limited to, myofascial release techniques, friction massage, and trigger point techniques.
7 Specifically, myofascial release is a soft tissue manual technique that involves
8 manipulation of the muscle, fascia, and skin. Skilled manual techniques (active and/or
9 passive) are applied to soft tissue to effect changes in the soft tissues, articular structures,
10 neural or vascular systems. Examples are facilitation of fluid exchange, restoration of
11 movement in acutely edematous muscles, or stretching of shortened connective tissue.
12 This procedure is considered medically necessary for treatment of restricted motion of
13 soft tissues in involved extremities, neck, and trunk. This procedure is considered
14 medically necessary for treatment of pain and restricted motion of soft tissues resulting in
15 functional deficits.

16 17 **Joint Mobilization**

18 Joint mobilization is utilized to reduce pain and increase joint mobility. Most often
19 mobilizations are indicated for extremity and spine conditions.

20 21 **Therapeutic Activities**

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

29 30 **Activities of Daily Living (ADL) Training**

31 This procedure is considered medically necessary to enable the patient to perform essential
32 activities of daily living, instrumental activities of daily living, and self-care including
33 bathing, feeding, preparing meals, toileting, dressing, walking, making a bed, and
34 transferring from bed to chair, wheelchair, or walker.

35 36 **Cognitive Skills Development**

37 This procedure is considered medically necessary for persons with acquired cognitive
38 deficits resulting from head trauma/concussion. It is not appropriate for persons without
39 potential for improvement. This procedure should be aimed at improving or restoring
40 specific functions which were impaired by an identified injury.

1 **Orthotic Management and Training**

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

9
10 **Prosthetic Training**

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

15
16 **Lymphedema Management**

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

18
19 **5.3 Precautions and Contraindications to Therapeutic Modalities and Procedures**

20 1. The use of thermotherapy is contraindicated for the following:

- 21 • Recent or potential hemorrhage
- 22 • Thrombophlebitis
- 23 • Impaired sensation
- 24 • Impaired mentation
- 25 • Malignant tumor
- 26 • IR irradiation of the eyes

27
28 Precautions for use of thermotherapy include:

- 29 • Acute injury or inflammation
- 30 • Pregnancy
- 31 • Impaired circulation
- 32 • Poor thermal regulation
- 33 • Edema
- 34 • Cardiac insufficiency
- 35 • Metal in the area
- 36 • Over an open wound
- 37 • Over areas where topical counterirritants have recently been applied
- 38 • Demyelinated nerve

- 1 2. The use of cryotherapy is contraindicated for the following:
- 2 • Cold hypersensitivity
 - 3 • Cold intolerance
 - 4 • Cryoglobulinemia
 - 5 • Paroxysmal cold hemoglobinuria
 - 6 • Raynaud disease or phenomenon
 - 7 • Over regenerating peripheral nerves
 - 8 • Over an area with circulatory compromise or peripheral vascular disease

9
10 Precautions for cryotherapy include:

- 11 • Over the superficial branch of a nerve
- 12 • Over an open wound
- 13 • Hypertension
- 14 • Poor sensation or mentation

15
16 3. The use of immersion hydrotherapy is contraindicated for the following:

- 17 • Cardiac instability
- 18 • Confusion or impaired cognition
- 19 • Maceration around a wound
- 20 • Bleeding
- 21 • Infection in the area to be immersed
- 22 • Bowel incontinence
- 23 • Severe epilepsy
- 24 • Suicidal patients

25
26 Precautions for full body immersion in hot or very warm water include:

- 27 • Pregnancy
- 28 • Multiple Sclerosis
- 29 • Poor thermal regulation

30
31 4. Contraindications for Traction include:

- 32 • Where motion is contraindicated
- 33 • Acute injury or inflammation
- 34 • Joint hypermobility or instability
- 35 • Peripheralization of symptoms with traction
- 36 • Uncontrolled hypertension

1 Precautions for Traction include:

- 2 • Structural diseases or conditions affecting the tissues in the area to be treated (e.g.,
- 3 tumor, infection, osteoporosis, RA, prolonged systemic steroid use, local radiation
- 4 therapy)
- 5 • When pressure of the belts may be hazardous (e.g., with pregnancy, hiatal hernia,
- 6 vascular compromise, osteoporosis)
- 7 • Displaced annular fragment
- 8 • Medial disc protrusion
- 9 • When severe pain fully resolves with traction
- 10 • Claustrophobia or other psychological aversion to traction
- 11 • Inability to tolerate prone or supine position
- 12 • Disorientation

13
14 Additional precautions for cervical traction:

- 15 • TMJ problems
- 16 • Dentures

17
18 5. The use of thermal shortwave diathermy (SWD) is contraindicated for the following

- 19 • Any metal in the treatment area or on/in the body.
- 20 • Malignancy
- 21 • Eyes
- 22 • Testes
- 23 • Growing epiphyses

24
25 Contraindications for all forms of SWD:

- 26 • Implanted or transcutaneous neural stimulators including cardiac pacemakers
- 27 • Pregnancy

28
29 Precautions for all forms of SWD:

- 30 • Near electronic or magnetic equipment
- 31 • Obesity
- 32 • Copper-bearing intrauterine contraceptive devices

33
34 6. Contraindications for use of Electrical Currents:

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

1 Precautions for electrical current use:

- 2 • Cardiac disease
- 3 • Impaired mentation
- 4 • Impaired sensation
- 5 • Malignant tumors
- 6 • Areas of skin irritation or open wounds

7. Contraindications to the use of ultrasound include:

- 9 • Malignant tumor
- 10 • Pregnancy
- 11 • Central Nervous Tissue
- 12 • Joint cement
- 13 • Plastic components
- 14 • Pacemaker or implantable cardiac rhythm device
- 15 • Thrombophlebitis
- 16 • Eyes
- 17 • Reproductive organs

18 Precautions for Ultrasound include:

- 19 • Acute inflammation
- 20 • Epiphyseal plates
- 21 • Fractures
- 22 • Breast implants

23
24
25 The use of electrical muscle stimulation, SWD, thermotherapy, cryotherapy, ultrasound,
26 laser/light therapy, immersion hydrotherapy, and mechanical traction with pediatric
27 patients is contraindicated if the patient cannot provide the proper feedback necessary for
28 safe application.

29
30 In addition to the contraindications listed above, there are a wide range of services which
31 are considered unproven, pose a significant health and safety risk, are scientifically
32 implausible and/or are not widely supported as evidence based. Such services would be
33 considered not medically necessary and include, but are not limited to:

- 34 • Axial/Spinal decompression
- 35 • Dry needling
- 36 • Laser therapy
- 37 • Manual muscle testing to diagnosis non-neuromusculoskeletal conditions
- 38 • 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)

6. 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.

6.1 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 rehabilitation 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 athletic trainer 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 Athletic Trainer is defined as the evaluation of a patient:

- For which this is their first encounter with the practitioner or practitioner group.
- Who presents with:

- 1 ○ A new injury or new condition; or
- 2 ○ The same or similar complaint after discharge from previous care.
- 3 • Choice of code is dependent upon the level of complexity.

4

5 The evaluation codes reflect three levels of patient presentation: low-complexity,
6 moderate-complexity, and high-complexity. Four components are used to select the
7 appropriate AT evaluation CPT code. These include:

- 8 1. History and physical activity profile;
- 9 2. Examination;
- 10 3. Clinical decision making;
- 11 4. Development of plan of care conducted by the physician or other qualified health
12 care professional.

13

14 Relevant CPT Codes: CPT 97169, 97170, and 97171 – Athletic Training evaluation

15

16 The athletic trainer evaluation:

- 17 • Is documented, dated, and appropriately authenticated by the athletic trainer who
18 performed it.
- 19 • Identifies the rehabilitative needs of the patient.
- 20 • Incorporates appropriate tests and measures to facilitate outcome measurement.
- 21 • Produces data that are sufficient to allow evaluation, diagnosis, prognosis, and the
22 establishment of a plan of care.

23

24 The athletic trainer establishes a plan of care and manages the needs of the patient
25 based on the examination, evaluation, diagnosis, and prognosis; identifies goals and
26 outcomes; describes the proposed intervention, including frequency and duration;
27 includes documentation that is dated and appropriately authenticated by the athletic
28 trainer who established the plan of care.

29

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

- 32 • The diagnosis along with the date of onset or exacerbation of the
33 disorder/diagnosis;
- 34 • A reasonable estimate of when the goals will be reached;
- 35 • Long-term and short-term goals that are specific, quantitative, and objective;
- 36 • Athletic Training evaluation pertinent findings;
- 37 • The frequency and duration of treatment;
- 38 • The specific treatment techniques and/or exercises to be used in treatment; and
- 39 • Signatures of the patient's athletic trainer.

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

9
 10 Re-evaluation services are considered medically necessary when all of the following
 11 conditions are met:

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

18
 19 **AND the following indication is documented:**

- 20 • An exacerbation or significant change in patient/client status or condition.

21
 22 Relevant CPT Codes: CPT 97172 – Athletic Training re-evaluation

23
 24 In order to reflect that continued AT services are medically necessary, intermittent progress
 25 reports must demonstrate that the individual is making functional progress.

26
 27 **6.2 Treatment Sessions**

28 An athletic training intervention is the purposeful interaction of the athletic trainer with the
 29 patient and, when appropriate, with other individuals involved in patient care, using various
 30 athletic training procedures and techniques to produce changes in the condition that are
 31 consistent with the diagnosis and prognosis. Athletic training interventions consist of
 32 coordination, communication, and documentation; patient-related and family/caregiver
 33 instruction; and procedural interventions. Athletic trainers aim to alleviate impairment and
 34 functional limitation by designing, implementing, and modifying therapeutic interventions.

35 An athletic training session may include:

- 36 • Therapeutic exercise, including neuromuscular reeducation, strengthening,
 37 coordination, and balance;
- 38 • Functional training in self-care and home management including activities of daily
 39 living (ADL) and instrumental activities of daily living (IADL);

- 1 • Functional training in and modification of environments (e.g., home, work, school,
- 2 or community), including body mechanics and ergonomics;
- 3 • Assessment, design, fabrication, application, fitting, and training in assistive
- 4 technology, adaptive devices, and orthotic devices;
- 5 • Training in the use of prosthetic devices;
- 6 • Electrotherapeutic modalities;
- 7 • Physical agents and mechanical modalities;
- 8 • Training of the patient, caregivers, and family/parents in home exercise and activity
- 9 programs;
- 10 • Skilled reassessment of the individual's problems, plan, and goals as part of the
- 11 treatment session.

12
13 Documentation of each treatment session should include at a minimum:

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

29
30 The plan of care may result in recommendations for additional services including

31 consultation or referral to appropriate disciplines. For example, discharge planning takes

32 into consideration achievement of anticipated goals and expected outcomes and provides

33 for appropriate follow-up or referral. Collaboration may be with physicians, dentists,

34 nurses, educators, social workers, physical therapists, occupational therapists, and other

35 personnel involved with the patient management.

36
37 The athletic training intervention:

- 38 • Is altered in accordance with changes in response or status;
- 39 • Is provided at a level that is consistent with current athletic trainer practice;
- 40 • Is interdisciplinary when necessary to meet the needs of the patient; and

- Is dated and appropriately authenticated by the athletic trainer.

6.3 Discharge/Discontinuation of Intervention

The athletic trainer discharges the patient from rehabilitation services when the anticipated goals or expected outcomes for the patient have been achieved. The athletic trainer discontinues intervention when the patient is unable to continue to progress toward goals or when the athletic trainer determines that the patient will no longer benefit from rehabilitative care or requires skilled services.

The athletic training discharge documentation includes:

- The status of the patient at discharge and the goals and outcomes attained;
- Appropriate date and authentication by the athletic trainer who performed the discharge (if necessary);
- 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; and
- 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.

6.4 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).

6.5 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.

7. 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 CQEs 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.

7.1 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.

1 **Maximum Therapeutic Benefit (MTB)**

2 MTB is the patient's health status when the application of skilled therapeutic services has
 3 achieved its full potential (which may or may not be the complete resolution of the patient's
 4 condition.) At the point of MTB, continuation of the same or similar skilled treatment
 5 approach will not significantly improve the patient's impairments and function during this
 6 episode of care.

7
 8 If the patient continues to have significant complaints, impairments, and documented
 9 functional limitations, one should consider the following:

- 10 • Altering the treatment regimen such as utilizing a different physiological approach
 11 to the treatment of the condition, or decreasing the use of passive care (modalities,
 12 massage etc.) and increasing the active care (therapeutic exercise) aspects of
 13 treatment to attain greater functional gains;
- 14 • Reviewing self-management program including home exercise programs; and/or
- 15 • Referring the patient for consultation by another health care practitioner for
 16 possible co-management or a different therapeutic approach.

17 **Preventive Services**

18 Preventive services are designed to reduce the incidence or prevalence of illness,
 19 impairment, and risk factors, and to promote optimal health, wellness, and function. These
 20 services are not designed or performed to treat or manage a specific health condition.
 21 (Preventive services may or may not be covered under specific clients or through ASH
 22 benefits.)
 23

24 **Acute**

25 The stage of an injury, illness, or disease, in which the presence of clinical signs and
 26 symptoms is less than six weeks in duration, typically characterized by the presence of one
 27 or more signs of inflammation or other adaptive response.
 28

29 **Sub-Acute**

30 The stage of an injury, illness, or disease, in which the presence of clinical signs and
 31 symptoms is greater than six weeks, but not greater than twelve weeks in duration.
 32

33 **Chronic**

34 The stage of an injury, illness, or disease, in which the presence of clinical signs and
 35 symptoms is greater than twelve weeks in duration.
 36

37 **Red Flag(s)**

38 Signs and symptoms presented through history or examination/assessment that warrant
 39 more detailed and immediate medical assessment and/or intervention.
 40

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.

7.2 Clinical Quality Evaluation

The goal of the CQEs 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 CQE 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 CQEs have the responsibility to approve appropriate care all services that are medically necessary. The CQEs 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 CQE 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,

1 treatment duration, number of Durable Medical Equipment (DME)/supplies/appliances,
 2 number of therapies, or other services from the original amount/length submitted for
 3 review. This decision may be due to any number of reasons, such as:

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

10
 11 Additional services may be submitted and reviewed for evaluation of the patient's response
 12 to the initial trial of care. If the practitioner or patient disagrees with the partial approval of
 13 services, they contact the CQE listed on their response form to discuss the case, submit
 14 additional documentation through the Reopen process, or submit additional documentation
 15 to appeal the decision through the Provider Appeals and Member Grievances process.

16 **Non-approval / Denial**

17 Occurs when none of the services submitted for review are determined to be medically
 18 necessary services. The most common causes for a non-approval/denial of all services are
 19 administrative or contractual in nature (e.g., ineligibility, reached plan benefit limits, non-
 20 coverage). Clinically, it is appropriate to deny continued/ongoing care if the patient's
 21 condition(s) are not, or are no longer, responding favorably to the services being rendered
 22 by the treating practitioner, or the patient has reached maximum therapeutic benefit.
 23
 24

25 **Additional / Continued Care**

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

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

37
 38 Any exacerbation or flare-up of the condition that contributes to the need for additional
 39 treatment/services must be clearly documented.

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

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

9
 10 The clinical information that the CQE expects to see when evaluating the documentation
 11 in support of the medical necessity of submitted treatment/services should be
 12 commensurate with the nature and severity of the presenting complaint(s) and scope of the
 13 practitioner of services and may include but is not limited to:

- 14 • History
- 15 • Physical Examination/Evaluation
- 16 • Documented Treatment Plan and Goals
- 17 • Estimated time of Discharge

18
 19 In general, the initiation of care is warranted if there are no contraindications to prescribed
 20 care, there is reasonable evidence to suggest the efficacy of the prescribed intervention,
 21 and the intervention is within the scope of services permitted by State or Federal law. The
 22 treatment submission for a disorder is typically structured in time-limited increments
 23 depending on clinical presentation. Dosage (frequency and duration of service) should be
 24 appropriately correlated with clinical findings, potential complications/barriers to recovery
 25 and clinical evidence. When the practitioner discovers that a patient is nonresponsive to
 26 the applied interventions within a reasonable time frame, re-assessment and treatment
 27 modification should be implemented and documented. If the patient's condition(s) worsen,
 28 the practitioner should take immediate and appropriate action to discontinue or modify care
 29 and/or make an appropriate healthcare referral.

30
 31 Services that do not require the professional skills of a practitioner to perform or supervise
 32 are not medically necessary., If a patient's recovery can proceed safely and effectively
 33 through a home exercise program or self-management program, services are not indicated
 34 or medically necessary.

35 36 **7.3 Critical Factors during Clinical Reviews**

37 The complexity and/or severity of historical factors, symptoms, examination findings, and
 38 functional deficits play an essential role to help quantify the patient's clinical status and
 39 assess the effectiveness of planned interventions over time. CQEs consider patient-specific
 40 variables as part of the medical necessity verification process. The entire clinical picture

1 must be taken into consideration with each case evaluated based upon unique patient and
2 condition characteristics.

3
4 Such variables may include, but not be limited to co-morbid conditions and other barriers
5 to recovery, the stage(s) of the condition(s), mechanism of injury, severity of the
6 symptoms, functional deficits, and exam findings, as well as social and psychological status
7 of the patient and the available support systems for self-care. In addition, the patient's age,
8 symptom severity, and the extent of positive clinical findings may influence duration,
9 intensity, and frequency of services approved as medically necessary. For example:

- 10 • Severe symptomatology, exam findings, and/or functional deficits may require
11 more care overall (e.g., longer duration, more services per encounter, and frequency
12 of encounters that the average); these patients require a higher frequency; but may
13 require short-term trials of care initially to assess patient response to care.
- 14 • Less severe symptomatology, exam findings and/or functional deficits usually
15 require less care (e.g., shorter duration, fewer services per encounter, and frequency
16 of encounters that the average); overall but may allow for less oversight and a
17 longer initial trial of care.
- 18 • As patients age, they may have a slower response to care, and this may affect the
19 approval of a trial of care.
- 20 • Because pediatric patients (under the age of 12) have not reached musculoskeletal
21 maturity, it may be necessary to modify the types of therapies approved as well as
22 shorten the initial trial of care.
- 23 • Complicating and/or co-morbid condition factors vary depending upon individual
24 patient characteristics, the nature of the condition/complaints, historical and
25 examination elements, and may require appropriate coordination of care and/or
26 more timely re-evaluation.

27
28 The following are examples of the factors CQEs consider when verifying the medical
29 necessity of rehabilitative services for musculoskeletal conditions and pain disorders.

30 **7.3.1 General Factors**

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

- 33 • Red Flags
- 34 • Yellow Flags (Psychosocial Factors)
- 35 • Co-morbid conditions (e.g., diabetes, inflammatory conditions, joint instability)
- 36 • Age (older or younger)
- 37 • Non-compliance with treatment and/or self-care recommendations
- 38 • Lack of response to appropriate care
- 39 • Lifestyle factors (e.g., smoking, diet, stress, deconditioning)
- 40

- 1 • Work and recreational activities
- 2 • Pre-operative/post-operative care
- 3 • Medication use (type and compliance)

4 5 Nature of Complaint(s)

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

9 10 History

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

18 19 Examination

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

23 24 **Assessment of Red Flags**

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

37
 38 Due to the rarity of actual red flag diagnoses in clinical practice, it is emphasized that the
 39 practitioner does not need to perform expensive or invasive diagnostic procedures (e.g., x-
 40 ray, advanced imaging, laboratory studies) in the absence of suspicious clinical

1 characteristics. Important red flags and events as well as the points during the clinical
2 encounter at which they are likely to appear include but may not be limited to:

3
4 Past or Current History

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

13
14 Present Complaint

- 15 • Writhing or cramping pain.
- 16 • Precipitation by significant trauma.
- 17 • Pain that is worse at night or not relieved by any position.
- 18 • Suspicion of cerebrovascular compromise.
- 19 • Symptom's indicative of progressive neurological disorder.

20
21 Physical Examination/Assessment

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

32
33 Pattern of Symptoms Not Consistent with Benign Disorder

- 34 • Chest tightness, difficulty breathing, chest pain.
- 35 • Headache of morbid proportion.
- 36 • Rapidly progressive neurological deficit.
- 37 • Significant, unexplained extremity weakness or clumsiness.
- 38 • Change in bladder or bowel function.
- 39 • New or worsening numbness or paresthesia.

- 1 • Saddle anesthesia.
- 2 • New or recent bilateral radiculopathy.

3 4 Lack of Response to Appropriate Care

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

10 11 **Assessment of Yellow Flags**

12 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.

16 If a yellow flag is identified during a medical necessity review, the reviewer should communicate with the provider of services as soon as possible by telephone and/or through standardized communication methods. CQE may recommend returning the patient back to the referring healthcare practitioner or referring the patient to other health care practitioner/specialist as appropriate.

22 23 **Assessment of Historical Information**

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

- 26 • The mechanism of onset and date of onset are congruent with the stated condition's etiology.
- 27 • The patient's past medical history and response to care do not pose contraindication(s) for the services submitted for review.
- 28 • The patient's past medical history of pertinent related and unrelated conditions does not pose contraindication(s) for the services submitted for review.
- 29 • The patient's complaint(s) have component(s) that are likely to respond favorably to services submitted for review.
- 30 • 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).
- 31 • 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).
- 32 • The quality, radiation, severity, and timing of pain are congruent with the documented condition(s) or disorder(s).

- 1 • The patient’s past medical history of having the same or similar condition(s)
- 2 indicates a favorable response to care.
- 3 • The absence or presence of co-morbid condition(s) may or may not present absolute
- 4 or relative contraindications to care.

6 **Assessment of Examination Findings**

- 7 • The exam procedures, level of complexity, and components are appropriate for the
- 8 patient’s complaint(s) and historical findings.
- 9 • Objective palpatory, orthopedic, neurologic, and other physical examination
- 10 findings are current, clearly defined, qualified, and quantified, including the nature,
- 11 extent, severity, character, professional interpretation, and significance of the
- 12 finding(s) in relation to the patient’s complaint(s) and differential diagnosis(es).
- 13 • Exam findings provide evidence justifying the condition(s) is/are likely to respond
- 14 favorably to services submitted for review.
- 15 • Exam findings provide a reasonable and reliable basis for the stated diagnosis(es).
- 16 • Exam findings provide a reasonable and reliable basis for treatment planning;
- 17 accounting for variables such as age, sex, physical condition, occupational and
- 18 recreational activities, co-morbid conditions, etc.
- 19 • The patient’s progress is being appropriately monitored each visit (as noted within
- 20 daily chart notes and during periodic re-exams) to ensure that acceptable clinical
- 21 progress is realized.

23 **Assessment of Treatment / Treatment Planning**

- 24 • Treatment dosage (frequency and duration of service) is appropriately correlated
- 25 with the nature and severity of the subjective complaints, potential
- 26 complications/barriers to recovery, and objective clinical evidence.
- 27 • Services that do not require the professional skills of a practitioner to perform or
- 28 supervise are not medically necessary, even if they are performed or supervised by
- 29 an Athletic Trainer. Therefore, if the continuation of a patient’s care can proceed
- 30 safely and effectively through a home exercise program or self-management
- 31 program, services are not indicated or medically necessary.
- 32 • The use of passive modalities in the treatment of subacute or chronic conditions
- 33 beyond the acute inflammatory response phase requires documentation of the
- 34 anticipated benefit and condition-specific rationale in order to be considered
- 35 medically necessary.
- 36 • The treatment plan includes the use of therapeutic procedures to address functional
- 37 deficits and ADL restrictions.
- 38 • The set therapeutic goals are functionally oriented, realistic, measurable, and
- 39 evidence based.
- 40 • The proposed date of release/discharge from treatment is clearly defined.

- 1 • The treatment/therapies are appropriately correlated with the nature and severity of
- 2 the patient's condition(s) and set treatment goals.
- 3 • Functional Outcome Measures (FOM) demonstrate minimal clinically important
- 4 difference (MCID) from baseline results through periodic reevaluations during the
- 5 course of care. This is important in order to determine the need for continued care,
- 6 the appropriate frequency of visits, estimated date of release from care, and if a
- 7 change in the treatment plan or a referral to an appropriate health care
- 8 practitioners/specialist is indicated.
- 9 • Home care, self-care, and active-care instructions are documented.
- 10 • Durable Medical Equipment (DME), supplies, appliances, and supports are
- 11 provided when medically necessary and appropriately correlated with clinical
- 12 findings and clinical evidence.

13 **Assessment of Diagnostic Imaging / Special Studies**

- 14 • Laboratory tests are performed only when medically necessary to improve
- 15 diagnostic accuracy and treatment planning. Abnormal values are professionally
- 16 interpreted as they relate to the patient's complaint(s) or to unrelated co-morbid
- 17 conditions that may or may not impact the patient's prognosis and proposed
- 18 treatment.
- 19 • X-ray procedures are performed only when medically necessary to improve
- 20 diagnostic accuracy and treatment planning. (Indicators from history and physical
- 21 examination indicating the need for x-ray procedures are described in the *X-Ray*
- 22 *Guidelines (CPG 1-S)* clinical practice guideline).
- 23 • Advanced imaging studies, when medically necessary and/or available, are
- 24 evaluated for structural integrity and to rule out osseous, related soft tissue
- 25 pathology, or other pathology.
- 26 • EMG and NCV studies, when medically necessary and/or available, are evaluated
- 27 for objective evidence of neural deficit. For more information, see the
- 28 *Electrodiagnostic Testing (CPG 129-S)* clinical practice guideline.
- 29 • Imaging or special studies' findings are appropriate given the nature and severity
- 30 of the patient's condition(s) and the findings obtained are likely to influence the
- 31 basis for the proposed treatment.
- 32

33 **7.3.2 Factors that Influence Adverse Determinations of Clinical Services (Partial Approvals/Denials)**

34 Factors that influence adverse determinations of clinical services may include but are not

35 limited to these specific considerations and other guidelines and factors identified

36 elsewhere in this policy.: Topics/factors covered elsewhere in this guideline are also

37 applicable in this section and may result in an adverse determination on medical necessity

38 review. To avoid redundancy, many of those factors have not been listed below.

39

40

1 **Additional Factors Considered in Determination of Medical Necessity**

2
3 **History / Complaints / Patient Reported Outcome Measures**

- 4 • The patient's complaint(s) and/or symptom(s) are not clearly described
- 5 • There is poor correlation and/or a significant discrepancy between the complaint(s)
- 6 and/or symptom(s) as documented by the treating practitioner and as described by
- 7 the patient
- 8 • The patient's complaint(s) and/or symptom(s) have not demonstrated clinically
- 9 significant improvement.
- 10 • The nature and severity of the patient's complaint(s) and/or symptom(s) are
- 11 insufficient to substantiate the medical necessity of any/all submitted services
- 12 • The patient has little or no pain as measured on a valid pain scale
- 13 • The patient has little or no functional deficits using a valid functional outcome
- 14 measure or as otherwise documented by the practitioner

15
16 **Evaluation Findings**

- 17 • There is poor correlation and/or a significant discrepancy in any of the following:
- 18 ○ patient's history
- 19 ○ subjective complaints
- 20 ○ objective findings
- 21 ○ diagnosis
- 22 ○ treatment plan
- 23 • The application of various exam findings to diagnostic or treatment decisions are
- 24 not clearly described or measured. (e.g., severity, intensity, professional
- 25 interpretation of results, significance)
- 26 • The patient's objective findings have not demonstrated clinically significant
- 27 improvement
- 28 • The objective findings are essentially normal or are insufficient to support the
- 29 medical necessity of any/all submitted services
- 30 • The submitted objective findings are insufficient due to any of, but not limited to,
- 31 the following reasons:
- 32 ○ old or outdated relative to the requested dates of service
- 33 ○ do not properly describe the patient's current status
- 34 ○ do not substantiate the medical necessity of the current treatment plan do
- 35 not support the patient's diagnosis/diagnoses do not correlate with the
- 36 patient's subjective complaint(s) and/or symptom(s)
- 37 • Not all of the patient's presenting complaints were properly examined
- 38 • The patient does not have any demonstrable functional deficits or impairments
- 39 • The patient has not made reasonable progress toward pre-clinical status or
- 40 functional outcomes under the initial treatment/services

- 1 • Clinically significant therapeutic progress is not evident through a review of the
- 2 submitted records; this may indicate that the patient has reached maximum
- 3 therapeutic benefit
- 4 • The patient is approaching or has reached maximum therapeutic benefit
- 5 • The patient's exam findings have returned to pre-injury status or prior level of
- 6 function
- 7 • There is inaccurate reporting of the patient's clinical findings
- 8 • The exam performed is for any of the following:
- 9 ○ wellness
- 10 ○ pre-employment
- 11 ○ sports pre-participation
- 12 • The exam performed is non-standard and solely technique/protocol based

14 **Diagnosis**

- 15 • The diagnosis is not supported by one or more of the following:
- 16 ○ patient's history (e.g., date/mechanism of onset)
- 17 ○ subjective complaints (e.g., nature and severity, location)
- 18 ○ objective findings (e.g., not clearly defined and/or quantified, not
- 19 professionally interpreted, significance not noted)

21 **Submitted Medical Records**

- 22 • The submitted records are insufficient to reliably verify pertinent clinical
- 23 information, such as (but not limited to):
- 24 ○ patient's clinical health status
- 25 ○ the nature and severity of the patient's complaint(s) and/or symptom(s)
- 26 ○ date/mechanism of onset
- 27 ○ objective findings
- 28 ○ diagnosis/diagnoses
- 29 ○ response to care
- 30 ○ functional deficits/limitations
- 31 • There are daily notes submitted for the same dates of service with different/altered
- 32 findings without an explanation
- 33 • There is evidence of duplicated or nearly duplicated records for the same patient
- 34 for different dates of service, or for different patients
- 35 • There is poor correlation and/or a significant discrepancy between the information
- 36 presented in the submitted records with the information presented during a verbal
- 37 communication between the reviewing CQE and treating practitioner
- 38 • The treatment time (in minutes) and/or the number of units used in the performance
- 39 of a timed service (e.g., modality, procedure) during each encounter/office visit was
- 40 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

- 1 • Additional significant improvement cannot be reasonably expected by continued
- 2 treatment and treatment must be changed or discontinued
- 3 • The patient has had ongoing care without any documented lasting therapeutic
- 4 benefits
- 5 • The condition requires an appropriate referral and/or coordination with other
- 6 appropriate health care services
- 7 • The patient is not complying with the treatment plan that includes lifestyle changes
- 8 to help reduce frequency and intensity of symptoms
- 9 • The patient is not adhering to treatment plan that includes medically necessary
- 10 frequency and intensity of services
- 11 • The use of multiple passive modalities with the same or similar physiologic effects
- 12 to the identical region is considered redundant and not reasonable or medically
- 13 necessary
- 14 • Home care, self-care, and active-care instructions are not implemented or
- 15 documented in the submitted records
- 16 • Uncomplicated diagnoses do not require services beyond the initial treatment plan
- 17 before discharging the patient to active home/self-care
- 18 • As symptoms and clinical findings improve the frequency of services (e.g., visits
- 19 per week/month) did not decrease.
- 20 • The submitted services do not or no longer require the professional skills of the
- 21 treating practitioner.
- 22 • The treatment plan is for any of the following:
- 23 ○ preventive care
- 24 ○ elective/convenience/wellness care
- 25 ○ back school
- 26 ○ vocational rehabilitation or return to work programs
- 27 ○ work hardening programs
- 28 ○ routine educational, training, conditioning, return to sport, or fitness.
- 29 ○ non-covered condition
- 30 • There is duplication of services with other healthcare practitioners/specialties
- 31 • The treatment plan is not supported due to, but not limited to, any of the following
- 32 reasons:
- 33 ○ technique-/protocol-based instead of individualized and evidence based
- 34 ○ generic and not individualized for the patient's specific needs
- 35 ○ does not correlate with the set therapeutic goals
- 36 ○ not supported in the clinical literature (e.g., proprietary, unproven)
- 37 ○ not considered evidence-based and/or professionally accepted
- 38 • The treatment plan includes services that are considered not evidence-based, not
- 39 widely accepted, unproven and/or not reasonable or medically necessary,
- 40 inappropriate or unrelated to the patient's complaint(s) and/or diagnosis/diagnoses.

1 (e.g., Low level laser therapy, axial/spinal decompression, select forms of EMS
 2 such as microcurrent, H-wave. Also see the *Techniques and Procedures Not Widely*
 3 *Supported as Evidence-Based (CPG 133 – S)* clinical practice guideline for
 4 complete list).

6 **Health and Safety**

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

16 **7.3.3 Referral / Coordination of Services**

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

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

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

37
 38 The Clinical Policy is reviewed and approved by the ASH Clinical Quality committees that
 39 are comprised of contracted network practitioners including practitioners of the same
 40 clinical discipline as the treating providers for whom compliance with the practices

1 articulated in this this document is required. Guidelines are updated at least annually, or as
 2 new information is identified that result in material changes to one or more of these
 3 policies.

4 **8. LITERATURE REVIEW**

5 **8.1 Rehabilitation for Conditions Considered Unproven**

6 **Scoliosis**

7 Scoliosis, lateral curvature of the spine, is a structural alteration that occurs in a variety of
 8 conditions. Progression of the curvature during periods of rapid growth can result in
 9 significant deformity, which may be accompanied by cardiopulmonary compromise
 10 (Schreiber et al., 2019; Scherl, 2016). Options for treatment of scoliosis include
 11 observation, bracing, and surgery. Evidence is insufficient to demonstrate effectiveness of
 12 scoliosis-specific exercises, (including the Schroth Method), chiropractic treatment,
 13 electrical stimulation, or biofeedback to correct, improve or prevent further curvature
 14 (Seleviciene et al., 2022; Santos et al., 2022; Fan et al., 2020; Schreiber et al., 2019; Scherl,
 15 2016; National Institutes of Health [NIH]/National Institute of Arthritis and
 16 Musculoskeletal and Skin Disease [NIAMS], 2019; American Academy of Orthopedic
 17 Surgeons [AAOS], 2019; Mehlman, 2020; Romano, et al., 2012).

18 Evidence is insufficient to demonstrate effectiveness of this treatment method to correct,
 19 improve or prevent further curvature.

20 **8.2 Specific Treatments Considered Unproven**

21 **Dry Hydrotherapy**

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

- 27 • Aqua Massage® (AMI Inc., Mystic, CT)
- 28 • AquaMED® (JTL Enterprises, Inc., Clearwater, FL)
- 29 • H2OMassage System™ (H2OMassage Systems, Winnipeg, MB, Canada)
- 30 • Hydrotherapy Tables (Sidmar Manufacturing, Inc., Princeton, MN)

31 Proponents of dry hydrotherapy maintain that it can be used in lieu of certain conventional
 32 physical medicine therapeutic modalities and procedures, such as heat packs, wet
 33 hydrotherapy, massage, and soft tissue manipulation. The assertions that have been made
 34 by manufacturers of this device at their websites have not yet been proven. No published
 35 studies or information regarding dry hydrotherapy devices or dry hydrotherapy treatment
 36 were identified in the peer-reviewed scientific literature. In the absence of peer- reviewed

1 literature demonstrating the effectiveness of dry hydrotherapy and in the absence of
 2 comparison to currently accepted treatment modalities, no definitive conclusions can be
 3 drawn regarding the clinical benefits of this treatment.

4
 5 **Non-invasive Interactive Neurostimulation (e.g., InterX®)**

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

8
 9 **Microcurrent Electrical Nerve Stimulation (MENS)**

10 For more information, see Electric Stimulation for Pain, Swelling and Function in the
 11 Clinic Setting (CPG 272 – S) clinical practice guideline.

12
 13 **H-WAVE®**

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

16
 17 **Taping/Elastic therapeutic tape (e.g., Kinesio™ tape, Spidertech™ tape)**

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

20
 21 **Dry Needling**

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

23
 24 **Laser Therapy (LLLT)**

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

26
 27 **Vertebral Axial Decompression Therapy and Devices**

28 Refer to *Axial/Spinal Decompression Therapy (CPG 83 – S) clinical practice guideline* for
 29 more information.

30
 31 **9. CODING/BILLING INFORMATION**

32 **Note:**

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

1 **Covered when medically necessary:**

| CPT®* Codes | 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 |
| 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) |

CPG 183 Revision 11 - S

Athletic Training Medical Policy/Guideline

Revised - August 15, 2023

To CHSO for review and approval 08/15/2023

CHSO reviewed and approved 08/15/2023

To CQT for informational review 09/11/2023

CQT reviewed as informational 09/11/2023

To QIC for informational review 10/03/2023

QIC reviewed as informational 10/03/2023

To QOC for review and adoption 10/19/2023

QOC reviewed and adopted 10/19/2023

| CPT®* Codes | Description |
|------------------------|---|
| 97140 | Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes |
| 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 |
| 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. |

| CPT®* Codes | Description |
|------------------------------|---|
| 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 |
| 97760 | Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes |
| 97761 | Prosthetic(s) training, upper and/or lower extremity(ies), 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 |

1
2
3

Training in Nature/Not Medically Necessary/Not Covered:

| CPT* Codes | Description |
|-----------------------------|---|
| 20560 | Needle insertion(s) without injection(s); 1 or 2 muscle(s) |
| 20561 | Needle insertion(s) without injection(s); 3 or more muscles |
| 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) |

4

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

1 Unproven and not covered when used to report constraint-induced movement therapy or
 2 dry hydrotherapy/aquamassage/hydromassage, equestrian therapy (e.g., hippotherapy),
 3 elastic therapeutic tape/taping, low-level laser therapy or vertebral axial decompression:
 4

| HCPCS Codes | 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 |
| S9090 | Vertebral axial decompression, per session |
| E0744 | Neuromuscular stimulator for scoliosis |

5 *Current Procedural Terminology (CPT®) ©Current Year American Medical Association:
 6 Chicago, IL.

7

8 **References**

9 American Medical Association. (current year). *Current Procedural Terminology (CPT)*
 10 *current year* (rev. ed.). Chicago: AMA.

11

12 Board of Certification. (2010). *The 2009 Athletic Trainer Role Delineation Study* Omaha,
 13 NE: Stephen B. Johnson.

14

15 Commission on Accreditation of Athletic Training Education (CAATE). *Professional*
 16 *Program Standards*; 2020. Retrieved on April 18, 2023 from
 17 <https://caate.net/Programs/Professional/Professional-Program-Standards>

18

19 Dry Hydromassage. Princeton, MN: Sidmar Manufacturing, Inc.; 2001-2005. Retrieved on
 20 April 18, 2023 from <http://www.sidmar.com/>

21

22 Fan Y, Ren Q, To MKT, Cheung JPY. Effectiveness of scoliosis-specific exercises for
 23 alleviating adolescent idiopathic scoliosis: a systematic review. *BMC Musculoskelet*
 24 *Disord.* 2020 Jul 27;21(1):495.

25

26 Mehlman CT. Idiopathic Scoliosis. Jun 30, 2004. Updated Jan 2023. *emedicine*. Retrieved
 27 on April 18, 2023 from <http://www.emedicine.com/orthoped/TOPIC504.HTM>

28

29 National Athletic Trainers’ Association. January, 2010 *Athletic Training Services: An*
 30 *Overview of Skills and Services Performed by Certified Athletic Trainers*. Retrieved

1 on April 18, 2023 from
 2 <http://www.nata.org/sites/default/files/GuideToAthleticTrainingServices.pdf>

3
 4 National Athletic Trainers Association. Home page. Retrieved April 18, 2023, from
 5 <http://www.nata.org>

6
 7 National Institutes of Health. National Institute of Arthritis and Musculoskeletal and Skin
 8 Disease. Questions and answers about scoliosis in children and adolescents. NIH
 9 Publication No. 13-4862. Dec 2019. Retrieved on April 18, 2023 from
 10 http://www.niams.nih.gov/Health_Info/Scoliosis/default.asp

11
 12 Romano M, Minozzi S, Bettany-Saltikov J, Zaina F, Chockalingam N, Kotwicki T, et al.
 13 Exercises for adolescent idiopathic scoliosis. *Cochrane Database Syst Rev*. 2012 Aug
 14 15;(8):CD007837.

15
 16 Santos TS, Oliveira KKB, Martins LV, Vidal APC. Effects of manual therapy on body
 17 posture: Systematic review and meta-analysis. *Gait Posture*. 2022;96:280-294.
 18 doi:10.1016/j.gaitpost.2022.06.010.

19
 20 Scherl SA. Adolescent idiopathic scoliosis: Management and prognosis. In: UpToDate,
 21 Post TW (Ed), UpToDate, Waltham, MA.

22
 23 Schreiber S, Parent EC, Hill DL, Hedden DM, Moreau MJ, Southon SC. Patients with
 24 adolescent idiopathic scoliosis perceive positive improvements regardless of change in
 25 the Cobb angle - Results from a randomized controlled trial comparing a 6-month
 26 Schroth intervention added to standard care and standard care alone. *SOSORT 2018*
 27 Award winner. *BMC Musculoskelet Disord*. 2019;20(1):319. Published 2019 Jul 8.

28
 29 Seleviciene V, Cesnaviciute A, Strukcinskiene B, Marcinowicz L, Strazdiene N,
 30 Genowska A. Physiotherapeutic Scoliosis-Specific Exercise Methodologies Used for
 31 Conservative Treatment of Adolescent Idiopathic Scoliosis, and Their Effectiveness:
 32 An Extended Literature Review of Current Research and Practice. *Int J Environ Res*
 33 *Public Health*. 2022;19(15):9240. Published 2022 Jul 28. doi:10.3390/ijerph19159240