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

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Product: **Specialty**

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: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations Re-evaluations and Consultations
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 (Therapeutic) 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

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DESCRIPTION

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

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

The determination of medically necessary care, as outlined in this guideline, protects against inappropriate care that may be wasteful, unsafe, and harmful to the patient, while assuring approved care is safe, appropriate, curative, and improves the patient's function and quality of life. To protect the health and safety of patients, American Specialty Health (ASH) has implemented medical necessity review strategies to educate practitioners of the need to implement methods to reduce clinical errors and improve patient safety. These medical necessity review strategies include encouraging practitioners to adopt evidence-based health care approaches to patient care, implement professional standards of care, and follow applicable care management guidelines. Conducting risk management procedures via medical necessity review minimizes potential adverse outcomes and harm to the patient and prevents wasteful, unsafe and inappropriate care.

Care approved through medical necessity review is safe, appropriate, and directed at specific treatment goal resolution to ensure clinical benefit and improvement to the patient's quality of life.

- For risk-reduction and the protection of patients, the review process does not approve treatment when a condition should be referred to a medical physician, the treatment is unsafe, or when treatment is not providing measurable health improvement.
- For the benefit of patients, the review process approves services when the evidence and practitioner treatment plan supports the use of conservative treatment for conditions known to be amenable to the services provided so that patients may recover from conditions without the need for more costly or high-risk treatments such as prescription opioids, injections, or surgery.

GUIDELINES

1. PROVIDERS OF ATHLETIC TRAINING SERVICES

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

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

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

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

- Perform evaluations and special tests – depending on state practice act
- Educate patients and answering questions
- Implement industrial/back to work programs
- Perform ergonomic assessments
- Do DME/brace fitting
- Perform therapeutic exercise and modality application
- Administer gait training
- Instruct in home exercise programs

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

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

Athletic Trainers provide services to patients to improve, adapt or restore functions that have been impaired or permanently lost as a result of acute, subacute, and chronic

neuromusculoskeletal conditions and/or certain medical conditions. Medically necessary athletic training services must relate to a written treatment plan of care and be of a level of complexity that requires the judgment, knowledge and skills of an Athletic Trainer (AT) to perform and/or supervise the services.

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

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

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

2. REHABILITATIVE ATHLETIC TRAINING SERVICES

Medically Necessary:

(1) Rehabilitative athletic training (AT) services to improve, adapt or restore functions which have been impaired or permanently lost as a result of acute, subacute, and

chronic neuromusculoskeletal conditions and certain medical conditions are considered medically necessary when **ALL** the following criteria are met*:*

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

*Reasonable and predictable period of time: The specific time frames for which one would expect practical functional improvement is dependent on various factors including whether the services are Rehabilitative services. A reasonable trial of care for rehabilitative services to determine the patient's potential for improvement in or restoration of function is influenced by the diagnosis; clinical evaluation findings; stage of the condition (acute, sub-acute, chronic); severity of the condition; and patient-specific elements (age, gender, past and current medical history, family history, and any relevant psychosocial factors).

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

Not Medically Necessary:

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

1. Rehabilitative services are **NOT** intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of acute, subacute, and chronic musculoskeletal conditions and certain medical conditions.

2. Improvement or restoration of function could reasonably be expected to improve as the individual gradually resumes normal activities without the provision of skilled AT services. For example:
    - A patient suffers a transient and easily reversible loss or reduction in function could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.
    - A fully functional patient who develops weakness from a brief period of bed rest.
3. AT services do **not** require the skills of a qualified practitioner of AT services. Examples include but are not limited to:
    - General exercises (basic aerobic, strength, flexibility or aquatic programs) to promote overall fitness/conditioning;
    - Services for the purpose of enhancing athletic or recreational sports performance or for return to sport after injury or surgery;
    - Massages and whirlpools for relaxation, basic flexibility or exercise programs, swimming and routine water aerobics programs; and
    - General public education/instruction sessions; or
    - Repetitive gait or other activities that an individual can practice independently or with a caregiver or routine re-evaluations.
        - Activities that require only routine supervision and NOT the skilled services of an athletic trainer.
        - When a home exercise program is sufficient and can be utilized to continue therapy (examples of exceptions include but would not be limited to the following: if patient has poor exercise technique that requires cueing and feedback, lack of support at home if necessary for exercise program completion, and/or cognitive impairment that doesn't allow the patient to complete the exercise program).
4. The expectation does **not** exist that the service(s) will result in a clinically significant improvement in the level of functioning within a reasonable and predictable period of time (up to 4 weeks).
        - If absent supervised care, function could reasonably be expected to improve at the same/similar rate as the individual gradually resumes normal activities, then the service is considered **not** medically necessary.
        - The patient's condition does not have the potential to improve or is not improving in response to therapy; or would not produce a meaningful improvement relative to the extent and duration of therapy required; and there is an expectation that further improvement is NOT attainable.
        - The documentation fails to objectively verify functional progress over a reasonable period of time (up to 4 weeks).
        - The patient has reached maximum therapeutic benefit.

5. A passive modality is **not** preparatory to other skilled treatment procedures or is not necessary in order to provide other skilled treatment procedures safely and effectively.
6. A passive modality has insufficient published evidence to support a clinically meaningful physiologic effect on the target tissue or improve the potential for a positive response to care for the condition being treated.
7. Reevaluations or assessments of a patient's status that are not necessary to continue a course of therapy nor related to a new condition or exacerbation for which the reevaluation will likely result in a change in the treatment plan.
8. The treatments/services are not supported by and are not performed in accordance with nationally recognized clinical standards or peer-reviewed literature as documented in applicable ASH CPGs or other literature accepted by ASH Clinical Quality committees.

(2) The following treatments/programs are **not** considered medically necessary because they are nonmedical, non-rehabilitative, educational, or training in nature. In addition, these treatments/programs are specifically excluded under many benefit plans:
1. Back school
2. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work
3. Work hardening programs
4. Health and wellness interventions.

(3) Rehabilitation for the treatment of any of the following conditions is considered unproven:
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 impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals. As an example, when individuals receive manual therapy services from an athletic trainer and physical therapist or chiropractor, the services must be documented as separate and distinct, performed on different body parts, and must be justified and non-duplicative.

5. THERAPEUTIC MODALITIES AND PROCEDURES

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

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

- Hot or cold packs
- Mechanical traction
- Unattended electrical stimulation (i.e., for pain relief)
- Vasopneumatic devices
- Whirlpool
- Paraffin bath
- Diathermy

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

- Contrast baths
- Ultrasound
- Attended electrical stimulation (i.e., NMES)
- Iontophoresis

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

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

Documentation Requirements to Substantiate Medical Necessity of Therapeutic Modalities and Procedures

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

5.1 Passive Care and Active Care

Passive Care

Passive care are those interventions applied to a patient with no active participation on the part of the patient. Passive care includes various skilled therapeutic procedures (e.g., chiropractic manipulation, manual therapy [CPT® 97140], acupuncture) as well as passive therapeutic modalities, such as heat, cold, electrical stimulation, and ultrasound. The following guidelines are relevant to the use of passive therapeutic modalities:

- Generally used to manage the acute inflammatory response, pain, and/or muscle tightness or spasm in the early stages of musculoskeletal and related condition management (e.g., short term and dependent upon patient condition and presentation; a few weeks). When the symptoms that prompted the use of certain passive therapeutic modalities begin to subside (e.g., reduction of pain, inflammation, and muscle tightness) and function improves, the medical record should reflect the discontinuation of those modalities, so as to determine the patient's ability to self-manage any residual symptoms.
- Use in the treatment of sub-acute or chronic conditions beyond the acute inflammatory response time frame requires documentation of the anticipated benefit and condition-specific rationale (e.g., exacerbation, inclusion with active care as an alternative for pharmacological management of chronic pain) to be considered medically necessary. Passive therapeutic modalities can be appropriate in these situations when they are preparatory and essential to the safe and effective delivery of other skilled therapeutic procedures (e.g., chiropractic manipulation, manual therapy [CPT® 97140], therapeutic exercise, acupuncture) that are considered medically necessary.
- Used as a stand-alone treatment is rarely therapeutic, and thus not required or indicated as the sole treatment approach to a patient's condition. Therefore, a treatment plan should not consist solely of passive therapeutic modalities but should also include skilled therapeutic procedures (e.g., chiropractic manipulation,

manual therapy [CPT® 97140], therapeutic exercise, acupuncture).

- Should be based on the most effective and efficient means of achieving the patient's functional goals. Seldom should a patient require more than one (1) or two (2) passive therapeutic modalities to the same body part during the therapy session. Use of more than two (2) passive therapeutic modalities on a single visit date and for a prolonged period is unusual and should be justified in the documentation for consideration of medical necessity.

Active Care

Active care involves therapeutic interventions that require patients to engage in specific exercises, movements, or activities to improve their health. Unlike passive care, which relies on external treatments (such as passive therapeutic modalities), active care emphasizes patient involvement and responsibility. Examples of active care include

- Therapeutic Exercise Prescription (CPT® Code 97110): This service may be considered when healthcare professionals are present and supervising tailored exercises performed by the patient based on the patient's condition, goals, and limitations. These exercises may be considered medically necessary to restore/develop strength, endurance, range of motion and flexibility which has been lost as a result of acute, subacute, and chronic neuromusculoskeletal conditions and certain medical conditions. (Refer to the "Treatment Interventions" section of this CPG for further information.)
- Neuromuscular Reeducation (NMR) (CPT® Code 97112): This service may be considered when healthcare professionals are present and supervising tailored exercises/movements performed by the patient for the purpose of retraining the connection of the brain and muscles, via the nervous system to improve balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities. This procedure may be considered medically necessary for impairments which affect the neuromuscular system. (Refer to the "Treatment Interventions" section of this CPG for further information.)
- Therapeutic Activities Prescription (CPT® code 97530): This service may be considered when healthcare professionals are present and supervising tailored therapeutic activities or functional activities performed by the patient to improve function when there has been a loss of mobility, strength, balance or coordination. This intervention may be considered necessary when a patient needs to improve function-based activities. (Refer to the "Treatment Interventions" section of this CPG for further information.)
- Independent Exercise Programs: Patients are provided with appropriate exercise routines to perform on their own (e.g., home exercise programs [HEP]). Supervised skilled care is provided in the development, modifications, and progressions of the HEP.

- Education and Self-Management: Patients receive education about their condition, proper body mechanics, and strategies to prevent recurrence. Empowering patients with knowledge helps them actively manage their health.

Use of various forms of active care should be started as soon as treatment is initiated and documented in the medical record, including instructions supporting independent exercise, education and self-management. Active therapeutic procedures requiring the supervision of a skilled practitioner (e.g., therapeutic exercise, therapeutic activities, NMR) are initiated as soon as possible to patient tolerance. Patients should progress from active therapeutic procedures requiring the supervision of a skilled practitioner to solely an independent exercise program as soon as reasonably possible.

The goal for active therapeutic procedures requiring the supervision of a skilled practitioner is to provide the necessary skilled care (e.g., exercise technique and movement correction, technique feedback, exercise program modification and/or exercise progression) to empower patients to successfully adopt and maintain an independent exercise program more efficiently and effectively than if they tried to do it on their own.

The length of time per session and the duration for medically necessary, active therapeutic procedures requiring the supervision of a skilled practitioner will vary depending upon multiple factors including but not limited to the patient's knowledge of exercise techniques and health status of the patient, the diagnosis, co-morbidities, phase of care, chronicity, and subjective and objective findings, especially the nature and severity of complaints, orthopedic, neurologic, and functional impairments.

The following guidelines are relevant to supervised therapeutic exercise (97110) and other active therapeutic procedures (e.g., 97112 and 97530) requiring the supervision of a skilled practitioner:

- For most patients, the duration of visits for medically necessary care typically does not exceed four (4) timed units, with the majority of codes utilized as active therapeutic procedures. The use of active therapeutic procedures is dependent upon patient tolerance and established goals. More than four (4) timed units per visit requires documentation to support this level of skilled care in the outpatient setting.
- More than two (2) or three (3) supervised active therapeutic procedure (e.g., 97110, 97112, 97530) sessions per week is expected to be a rare occurrence. Frequency of greater than three (3) times per week requires documentation to support this level of supervision.
- The duration of the treatment plan for active therapeutic procedures (e.g., 97110, 97112, 97530) varies based on the patient's condition, progress, treatment goals, and whether skilled services are necessary. It may span a visit or two, or several weeks or months, with periodic sessions to achieve functional improvement and address specific deficits. Certain patient factors may influence this duration (e.g.,

post-surgical status; significant trauma; significant orthopedic/neurological findings).

5.2 Treatment Interventions

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

Hydrotherapy/Whirlpool/Hubbard Tank

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

Fluidotherapy®

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

Vasopneumatic Devices

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

Hot/Cold Packs

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

Paraffin Bath

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

Mechanical Traction

This device provides a mechanical pull on the spine (cervical or lumbar) to relieve pain, spasm, and nerve root compression. Mechanical traction may be considered medically necessary only when there is no improvement after the application of other evidence-based therapeutic procedures to significantly improve symptoms for 3 weeks; the patient has signs of nerve root compression or radiculopathy; it is used in combination with other evidence-based treatments including therapeutic exercise with extension movements. A table or chair with moving rollers used against the spine or paraspinal tissues (e.g., Spinalator, AKA intersegmental traction) is not a form of mechanical traction.

Axial Decompression Therapy (AKA Decompression Therapy or Spinal Decompression Therapy) is considered unproven 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 which has been lost as a result of acute, subacute, and chronic neuromusculoskeletal conditions and certain medical conditions. Exercise performed by the patient within a clinic facility or other location (e.g., home, gym) without a physician or therapist present and supervising would be considered not medically necessary.

Neuromuscular Re-education (NMR)

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

Aquatic Therapy

Pool therapy (aquatic therapy) is provided individually, in a pool, to debilitated or neurologically impaired individuals. (The term is not intended to refer to relatively normal functioning individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.) The goal

is to develop and/or maintain muscle strength and range of motion by reducing forces of gravity through total or partial body immersion (except for head). Aquatic therapy may be considered medically necessary to develop and/or maintain muscle strength and range of motion when it is necessary to reduce the force of gravity through partial body immersion.

Gait Training

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

Therapeutic Massage

Therapeutic Massage involves the application of fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands and may be considered medically necessary when performed to restore muscle function, reduce edema, improve joint motion, or relieve muscle spasm caused by a specific condition or injury.

Soft Tissue Mobilization

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

Joint Mobilization

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

Therapeutic Activities

Therapeutic activities or functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities may be considered medically necessary) to improve function when there has been a loss or restriction of mobility,

strength, balance or coordination. These dynamic activities must be part of an active treatment plan and directed at a specific outcome. This intervention may be considered medically necessary after a patient has completed exercises focused on strengthening and range of motion but needs to improve function-based activities.

Activities of Daily Living (ADL) Training

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

Self-Care/Home Management Training

Self-Care/Home Management Training involves instructing and training patients with impairments in essential activities of daily living (ADL) and self-care activities (e.g., bathing, feeding, dressing, preparing meals, toileting, walking, making bed, and transferring from bed to chair, wheelchair or walker). This also includes compensatory training for ADLs, safety procedures, and instructions in the use of adaptive equipment and assistive technology for use in the home environment. Self-Care/Home Management Training may be considered medically necessary only when training is designed to address specific needs and goals of the patient for self-management skill development.

Cognitive Skills Development

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

Orthotic Management and Training

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

Prosthetic Training

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

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

5.3 Precautions and Contraindications to Therapeutic Modalities and Procedures

Thermotherapy:
The use of thermotherapy is contraindicated for the following:

- Recent or potential hemorrhage
- Thrombophlebitis
- Impaired sensation
- Impaired mentation
- Local malignant tumor
- IR irradiation of the eyes
- Infected areas

Precautions for use of thermotherapy include:

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

Cryotherapy:
The use of cryotherapy is contraindicated for the following:

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

Precautions for cryotherapy include:

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

Hydrotherapy:

The use of immersion hydrotherapy is contraindicated for the following:

- Cardiac instability
- Confusion or impaired cognition
- Maceration around a wound
- Bleeding
- Infection in the area to be immersed
- Bowel incontinence
- Severe epilepsy
- Patients with suicidal ideation
- Impaired mentation

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

- Pregnancy
- Multiple Sclerosis
- Poor thermal regulation

Mechanical Traction

Contraindications for mechanical traction include:

- Where motion is contraindicated
- Acute injury or inflammation
- Joint hypermobility or instability
- Peripheralization of symptoms with traction
- Uncontrolled hypertension
- Congenital spinal deformity
- Fractures
- Impaired mentation

Precautions for mechanical traction include:

- Structural diseases or conditions affecting the tissues in the area to be treated (e.g., tumor, infection, osteoporosis, RA, prolonged systemic steroid use, local radiation therapy)

- When pressure of the belts may be hazardous (e.g., with pregnancy, hiatal hernia, vascular compromise, osteoporosis)
- Cardiovascular disease
- Displaced annular fragment
- Medial disc protrusion
- Cord compression
- When severe pain fully resolves with traction
- Claustrophobia or other psychological aversion to traction
- Inability to tolerate prone or supine position
- Disorientation

Additional precautions for *cervical* traction:

- TMJ problems
- Dentures

Shortwave Diathermy:

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

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

Contraindications for all forms of SWD:

- Implanted or transcutaneous neural stimulators including cardiac pacemakers
- Pregnancy
- Impaired sensation
- Impaired mentation
- Infected areas

Precautions for all forms of SWD:

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

Electrical currents:

Contraindications for use of electrical currents:

- Demand pacemakers, implantable defibrillator, or unstable arrhythmia

- Placement of electrodes over carotid sinus and heart
- Areas where venous or arterial thrombosis or thrombophlebitis is present
- Pregnancy – over or around the abdomen or low back
- Infected areas

Precautions for electrical current use:

- Cardiac disease
- Impaired mentation
- Impaired sensation
- Malignant tumors
- Areas of skin irritation or open wounds

Ultrasound:

Contraindications to the use of ultrasound include:

- Malignant tumor
- Pregnant uterus
- Central nervous tissue
- Joint cement
- Plastic components
- Pacemaker or implantable cardiac rhythm device
- Thrombophlebitis
- Eyes
- Reproductive organs
- Impaired sensation
- Impaired mentation
- Infected areas

Precautions for ultrasound include:

- Acute inflammation
- Epiphyseal plates
- Fractures
- Breast implants

Pediatric Patients:

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

Unproven:

In addition to the contraindications listed above, there are a wide range of services which are considered unproven, pose a significant health and safety risk, are scientifically

implausible and/or are not widely supported as evidence based. Such services would be considered not medically necessary and include, but are not limited to:

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

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

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

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

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

The athletic trainer evaluation:

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

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

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

- The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis
- A reasonable estimate of when the goals will be reached

- Long-term and short-term goals that are specific, quantitative, and objective
- Athletic Training evaluation pertinent findings
- The frequency and duration of treatment
- The specific treatment techniques and/or exercises to be used in treatment
- Signatures of the patient's athletic trainer

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

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

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

AND the following indication is documented:

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

Relevant CPT® Codes: 97172 – Athletic Training re-evaluation

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

6.2 Treatment Sessions

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

An athletic training session may include:

- Therapeutic exercise, including neuromuscular reeducation, strengthening, coordination, and balance
- Functional training in self-care and home management including activities of daily living (ADL) and instrumental activities of daily living (IADL)
- Functional training in and modification of environments (e.g., home, work, school, or community), including body mechanics and ergonomics
- Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices
- Training in the use of prosthetic devices
- Electrotherapeutic modalities
- Physical agents and mechanical modalities
- Training of the patient, caregivers, and family/parents in home exercise and activity programs
- Skilled reassessment of the individual's problems, plan, and goals as part of the treatment session

Documentation of treatment should include:

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

The plan of care may result in recommendations for additional services including consultation or referral to appropriate disciplines. For example, discharge planning takes into consideration achievement of anticipated goals and expected outcomes and provides for appropriate follow-up or referral. Collaboration may be with physicians, dentists, nurses, educators, social workers, physical therapists, occupational therapists, and other personnel involved with the patient management.

The athletic training intervention:

- Is altered in accordance with changes in response or status;
- Is provided at a level that is consistent with current athletic trainer practice;
- 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
- Final functional status
- Proposed self-care recommendations, if applicable
- Referrals to other health care practitioners/referring physicians, as appropriate
- If the patient self- discharges, documentation of final status and if known, the reason for discontinuation of services.

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 (AKA 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.

Maximum Therapeutic Benefit (MTB)

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

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

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

Preventive Services

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

Acute

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

Sub-Acute

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

Chronic

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

Red Flag(s)
Signs and symptoms presented through history or examination/assessment that warrant more detailed and immediate medical assessment and/or intervention.

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

Co-Morbid Condition(s)
The presence of a concomitant condition, that may inhibit, lengthen, or alter in some way the expected response or approach to care.

Health Equity (HE)
The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Centers for Medicare & Medicaid Services, 2024).

Social Determinants of Health (SDoH)
The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Five domains: 1) Economic stability; 2) Education access and quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5) Social and community context (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

7.2 Clinical Review for Medical Necessity

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, stabilize, or functionally improve a chronic condition, as supported by the documentation presented. The CQE is to evaluate if the documentation and other clinical information presented by the practitioner 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 practitioner; and
- Demonstration of progression toward active home/self-care and discharge.

Partial Approval

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

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

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

Non-approval / Denial

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

Additional / Continued Care

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

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

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

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

- History
- Physical examination/evaluation
- Documented treatment plan and goals
- Estimated time of discharge

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

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

7.3 Critical Factors during Clinical Reviews

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

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

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

Health equity is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health. Factors that can impede health equity include, but are not limited to, race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, and preferred language. Social Determinants of Health (SDoH) are important influences on health equity status. SDoH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. There are typically five domains of SDoH: 1) Economic stability; 2) Education access and quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5) Social and community context. These barriers to health equity may impact health care

access, the patient presentation, clinical evaluations, treatment planning, and patient outcomes which may in turn influence medical necessity considerations.

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

7.3.1 General Factors

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

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

Nature of Complaint(s)

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

History

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

Examination

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

Assessment of Red Flags

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

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

Past or Current History

- Personal or family history of cancer
- Current or recent urinary tract, respiratory tract, or other infection
- Anticoagulant therapy or blood clotting disorder
- Metabolic bone disorder (osteopenia and osteoporosis)
- Unintended weight loss
- Significant trauma sufficient to cause fracture or internal injury
- Unexplained dizziness or hearing loss
- Trauma with skin penetration
- Immunosuppression (AIDS/HIV/ARC)
- Intravenous drug abuse, alcoholism
- Prolonged corticosteroid use
- Previous adverse reaction to substances or other treatment modalities
- Use of substances or treatment which may contraindicate proposed services
- Uncontrolled health condition (e.g., diabetes, hypertension, asthma)

Present Complaint

- Writhing or cramping pain
- Precipitation by significant trauma
- Pain that is worse at night or not relieved by any position
- Suspicion of vascular/cerebrovascular compromise
- Symptom’s indicative of progressive neurological disorder
- Unexplained dizziness or hearing loss

- Complaint inconsistent with reported mechanism of injury and/or evaluation findings
- Signs of psychological distress

Physical Examination/Assessment

- Inability to reproduce symptoms of musculoskeletal diagnosis or complaints
- Fever, chills, or sweats without other obvious source
- New or recent neurologic deficit (e.g., special senses, peripheral sensory, motor, language and cognitive)
- Positive vascular screening tests (e.g., carotid stenosis, vertebrobasilar insufficiency, abdominal aortic aneurysm)
- Abnormal vital signs
- Uncontrolled hypertension
- Signs of nutritional deficiency
- Signs of allergic reaction requiring immediate attention
- Surface lesions or infections in area to be treated
- Widespread or multiple contusions
- Unexplained severe tenderness or pain
- Signs of abuse/neglect

Signs of psychological distress

Pattern of Symptoms Not Consistent with Benign Disorder

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

Lack of Response to Appropriate Care

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

Assessment of Yellow Flags

When yellow flags are present, clinicians need to be vigilant for deviations from the normal course of illness and recovery. Examples of yellow flags include depressive symptoms,

injuries still in litigation, signs, and symptoms not consistent with pain severity, and behaviors incongruent with underlying anatomic and physiologic principles.

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

Assessment of Historical Information

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

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

Assessment of Examination Findings

- The exam procedures, level of complexity, and components are appropriate for the patient's complaint(s) and historical findings.
- Objective palpatory, orthopedic, neurologic, and other physical examination findings are current, clearly defined, qualified, and quantified, including the nature, extent, severity, character, professional interpretation, and significance of the finding(s) in relation to the patient's complaint(s) and differential diagnosis(es).

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

Assessment of Treatment / Treatment Planning

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

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

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

Additional Factors Considered in Determination of Medical Necessity

History / Complaints / Patient Reported Outcome Measures

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

Evaluation Findings

- There is poor correlation and/or a significant discrepancy in any of the following:
    - patient's history
    - subjective complaints
    - objective findings
    - diagnosis
    - treatment plan
- The application of various exam findings to treatment decisions are not clearly described or measured. (e.g., severity, intensity, professional interpretation of results, significance)
- The patient's objective findings have not demonstrated clinically significant improvement
- The objective findings are essentially normal or are insufficient to support the medical necessity of any/all submitted services
- The submitted objective findings are insufficient due to any of, but not limited to, the following reasons:
    - old or outdated relative to the requested dates of service
    - do not properly describe the patient's current status

    - do not substantiate the medical necessity of the current treatment plan do not support the patient's diagnosis/diagnoses do not correlate with the patient's subjective complaint(s) and/or symptom(s)
- Not all of the patient's presenting complaints were properly examined
- The patient does not have any demonstrable functional deficits or impairments
- The patient has not made reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services
- Clinically significant therapeutic progress is not evident through a review of the submitted records; this may indicate that the patient has reached maximum therapeutic benefit
- The patient is approaching or has reached maximum therapeutic benefit
- The patient's exam findings have returned to pre-injury status or prior level of function
- There is inaccurate reporting of the patient's clinical findings
- The exam performed is for any of the following:
    - wellness
    - pre-employment
    - sports pre-participation
- The exam performed is non-standard and solely technique/protocol based

Diagnosis

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

Submitted Medical Records

- The submitted records are insufficient to reliably verify pertinent clinical information, such as (but not limited to):
    - patient's clinical health status
    - the nature and severity of the patient's complaint(s) and/or symptom(s)
    - date/mechanism of onset
    - objective findings
    - diagnosis/diagnoses
    - response to care
    - functional deficits/limitations
- There are daily notes submitted for the same dates of service with different/altered findings without an explanation
- There is evidence of duplicated or nearly duplicated records for the same patient for different dates of service, or for different patients

- There is poor correlation and/or a significant discrepancy between the information presented in the submitted records with the information presented during a verbal communication between the reviewing CQE and treating practitioner
- The treatment time (in minutes) and/or the number of units used in the performance of a timed service (e.g., modality, procedure) during each encounter/office visit was not documented
- Some or all of the service(s) submitted for review are not documented as having been performed in the daily treatment notes

Treatment / Treatment Planning

- The submitted records show that the nature and severity of the patient's complaint(s) and/or symptom(s) require a limited, short trial of care in order to monitor the patient's response to care and determine the efficacy of the current treatment plan. This may include, but not limited to, any of the following:
    - significant trauma affecting function
    - acute/sub-acute stage of condition
    - moderate-to-severe or severe subjective and objective findings
    - possible neurological involvement
    - presence of co-morbidities that may significantly affect the treatment plan and/or the patient's response to care
- There is poor correlation of the treatment plan with the nature and severity of the patient's complaint(s) and/or symptom(s), such as (but not limited to):
    - use of acute care protocols for chronic condition(s)
    - prolonged reliance on passive care
    - active care and reduction of passive care are not included in the treatment plan
    - 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, and/or shorter total duration to discharge)
- The patient's symptoms and/or exam findings are mild and the patient's treatment plan requires a lesser frequency (e.g., units of services, office visits per week) and/or total duration
- Therapeutic goals have not been documented; goals should be measurable and written in terms of function and include specific parameters

- Therapeutic goals have not been reassessed in a timely manner to determine if the patient is making expected progress
- Failure to make progress or respond to care as documented within subjective complaints, objective findings and/or functional outcome measures
- The patient's condition(s) is/are not amenable to the proposed treatment plan
- Additional significant improvement cannot be reasonably expected by continued treatment, therefore treatment must be changed or discontinued
- The patient has had ongoing care without any documented lasting therapeutic benefits
- The condition requires an appropriate referral and/or coordination with other appropriate health care services
- The patient is not complying with the treatment plan that includes lifestyle changes to help reduce frequency and intensity of symptoms
- The patient is not adhering to treatment plan that includes medically necessary frequency and intensity of services without documented extenuating circumstances
- The use of multiple passive modalities with the same or similar physiologic effects to the identical region is considered redundant and not reasonable or medically necessary
- Home care, self-care, and active-care instructions are not implemented or documented in the submitted records
- Uncomplicated diagnoses do not require services beyond the initial treatment plan before discharging the patient to active home/self-care (e.g., mild knee pain that can be managed with a home exercise program)
- As symptoms and clinical findings improve the frequency of services (e.g., visits per week/month) did not decrease.
- The submitted services do not or no longer require the professional skills of the treating practitioner.
- The treatment plan is for any of the following:
    - preventive care
    - elective/convenience/wellness care
    - back school
    - vocational rehabilitation or return to work programs
    - work hardening programs
    - routine educational, training, conditioning, return to sport, or fitness.
    - non-covered condition
- There is duplication of services with other healthcare practitioners/specialties
- The treatment plan is not supported due to, but not limited to, any of the following reasons:
    - technique-/protocol-based instead of individualized and evidence based
    - generic and not individualized for the patient's specific needs
    - does not correlate with the set therapeutic goals

- not supported in the clinical literature (e.g., proprietary, unproven)
- not considered evidence-based and/or professionally accepted

- The treatment plan includes services that are considered not evidence-based, not widely accepted, unproven and/or not medically necessary, inappropriate or unrelated to the patient's complaint(s) and/or diagnosis/diagnoses. (e.g., Low level laser therapy, axial/spinal decompression, select forms of EMS such as microcurrent, H-wave. Also see the *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133 – S)* clinical practice guideline for complete list).

Health and Safety

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

7.3.3 Referral / Coordination of Services

When a potential health and safety issue is identified, the CQE must communicate with the practitioner of services as soon as possible by telephone and/or through standardized communication methods to recommend returning the patient back to the referring health care practitioner or referring the patient to other appropriate health care practitioner/specialist with the measure of urgency as warranted by the history and clinical findings. Such referral does not preclude coordinated cotreatment if / when applicable and documented as such.

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

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

- Inability to provoke symptoms with standard exam;
- Treatment needed outside of scope of practice.

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

8. EVIDENCE REVIEW

8.1 Rehabilitation for Conditions Considered Unproven

Scoliosis

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

Scoliosis in itself is generally not predictive of pain or dysfunction. The clinical presentation of scoliosis can vary greatly, ranging from minimal or no symptoms, to severe pain and disability. The presence of scoliosis can result in chronic pain, radicular symptoms and even restriction of lung capacity. However, most patients with scoliosis do not have symptoms. Physical therapists should focus on treating the symptoms of the patient with scoliosis as they would any other patient with back pain.

8.2 Specific Treatments Considered Unproven

Dry Hydrotherapy

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

- Aqua Massage® (AMI Inc., Mystic, CT)

- AquaMED® (JTL Enterprises, Inc., Clearwater, FL)
- H2OMassage System™ (H2OMassage Systems, Winnipeg, MB, Canada)
- Hydrotherapy Tables (Sidmar Manufacturing, Inc., Princeton, MN)

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

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

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

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

Taping/Elastic therapeutic tape (e.g., Kinesio™ tape, Spidertech™ tape)
Refer to *Strapping and Taping (CPG 143 – S) clinical practice guideline* for more information.

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

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

Vertebral Axial Decompression Therapy and Devices
Refer to Axial/Spinal Decompression Therapy (CPG 83 – S) clinical practice guideline for more information.

9. CODING/BILLING INFORMATION

Note:

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

Covered when medically necessary:

CPT® Code	CPT® Code Description
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

CPT® Code	CPT® Code Description
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
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

CPT® Code	CPT® Code Description
	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.
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

Training in Nature/Not Medically Necessary/Not Covered:

CPT® Code	CPT® Code 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)

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

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

HCPCS Code	HCPCS Code Description
S8940	Equestrian/hippotherapy, per session
S8948	Application of a modality (requiring constant practitioner attendance) to one or more areas, low-level laser; each 15 minutes
S9090	Vertebral axial decompression, per session
E0744	Neuromuscular stimulator for scoliosis

References

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

American Medical Association (current year). HCPCS Level II. American Medical Association

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

Centers for Medicare & Medicaid Services (CMS). (2024). CMS framework for health equity 2022-2032. Retrieved July 9, 2024 from https://www.cms.gov/pillar/health-equity#:~:text=To%20CMS%2C%20health%20equity%20means,preferred%20language%2C%20or%20other%20factors

Commission on Accreditation of Athletic Training Education (CAATE). Professional Program Standards; 2020. Retrieved on June 20, 2024 from https://caate.net/Programs/Professional/Professional-Program-Standards

Dry Hydromassage. Princeton, MN: Sidmar Manufacturing, Inc.; 2001-2005. Retrieved on June 20, 2024 from http://www.sidmar.com/

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

Mehlman CT. Idiopathic Scoliosis. Jun 30, 2004. Updated Jan 2023. emedicine. Retrieved on June 20, 2024 from http://www.emedicine.com/orthoped/TOPIC504.HTM

National Athletic Trainers' Association. January, 2010 Athletic Training Services: An Overview of Skills and Services Performed by Certified Athletic Trainers. Retrieved on June 20, 2024 from http://www.nata.org/sites/default/files/GuideToAthleticTrainingServices.pdf

National Athletic Trainers Association. Home page. Retrieved June 20, 2024, from http://www.nata.org

National Institutes of Health. National Institute of Arthritis and Musculoskeletal and Skin Disease. Questions and answers about scoliosis in children and adolescents. NIH Publication No. 13–4862. Dec 2019. Retrieved on June 20, 2024 from http://www.niams.nih.gov/Health_Info/Scoliosis/default.asp

Office of Disease Prevention and Health Promotion. (n.d.). Social Determinants of Health. Healthy People 2020. U.S. Department of Health and Human Services. Retrieved July 9, 2024 from https://health.gov/healthypeople/priority-areas/social-determinants-health#:~:text=Social%20determinants%20of%20health%20

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

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

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

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

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