



# **2026 Evolent Clinical Guidelines for Medical Necessity Review**

PHYSICAL MEDICINE GUIDELINES

Effective July 1, 2026 – July 1, 2027

# Guidelines for Clinical Review Determination

## **Preamble**

Evolent is committed to the philosophy of supporting safe and effective treatment for patients. The medical necessity criteria that follow are guidelines for the provision of diagnostic imaging. These criteria are designed to guide both providers and reviewers to the most appropriate diagnostic tests based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice will be used when applying the guidelines. Determinations are made based on both the guideline and clinical information provided at the time of the request. It is expected that medical necessity decisions may change as new evidence-based information is provided or based on unique aspects of the patient's condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient.

## **Guideline Development Process**

These medical necessity criteria were developed by Evolent for the purpose of making clinical review determinations for requests for therapies and diagnostic procedures. The developers of the criteria sets included representatives from the disciplines of radiology, internal medicine, nursing, cardiology, and other specialty groups. Evolent's guidelines are reviewed yearly and modified when necessary following a literature search of pertinent and established clinical guidelines and accepted diagnostic imaging practices.

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### General

- Active Procedures, Passive Treatment, and Experimental, Unproven, or Investigational Services
- Measurable Progressive Improvement



# Evolut Clinical Guideline 1512 for Outpatient Habilitative Physical, Occupational, Speech, and Rehabilitative Speech Therapy

<b>Guideline Number:</b> Evolut_CG_1512		
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<b>Original Date:</b> July 2026	<b>Last Revised Date:</b> December 2025	<b>Implementation Date:</b> July 2026

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## STATEMENT

### General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

### Purpose

This guideline describes the documentation requirements for an episode of care for outpatient habilitative physical, occupational, or speech therapy and rehabilitative speech therapy.

All recommendations in this guideline reflect practices that are evidence-based and/or supported by broadly accepted clinical specialty standards.

### Scope (1,2)

This guideline applies to all physical medicine practitioners. If a service can be self-administered safely and effectively by an unskilled person without the direct supervision of a therapist, then the service cannot be regarded as a skilled therapy service even if a therapist rendered the service. The unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist renders the service.

Evolent will review all requests resulting in adverse determinations for Medicaid members for coverage under federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.

## INDICATIONS

The following criteria must be addressed to justify the medical necessity of the prescribed treatment. Medically necessary services are reasonable or necessary, and require:

- Specific training, skills, and knowledge of a physical, occupational, or speech therapist to:
  - Diagnose, correct, or significantly improve/optimize a condition.
  - Prevent deterioration or development of additional physical and mental health conditions.
- Complexity of care that can only be safely and effectively performed by or under the

general supervision of a skilled therapist.

- Evidence of a current functional delay or deficit for age, as detailed in this guideline.
- A reasonable expectation that the services will bring about significant improvement within a reasonable time frame, regardless of whether the patient (member) has a coexisting disorder.
  - Measurable improvement and progress towards functional goals within an anticipated and reasonable timeframe toward a member's maximum potential
  - Ongoing treatment is not appropriate when a steady state of sensorimotor functioning, member function, and/or treatment has yielded no significant measurable functional progress over a reasonable amount of time.

## Documentation Requirements (3–6)

- Have a written referral from primary care practitioner or other non-physician practitioner (NPP) if required by state guidelines.
- Physical, occupational, and speech therapy initial evaluations and re-evaluations that include:
  - Member history - such as recent illness, injury or disability, and treatment history
  - Diagnosis and date of onset and/or exacerbation of the condition
  - Prior and current level of function
  - Current and baseline objective measures and/or testing demonstrating delay, as detailed in the “Establishing a Delay or Deficit” section and noted in this guideline.
    - Identification of any underlying factors that have impacted current functional performance must also be noted.
  - SMART goals and current goal status, as detailed in the “Plan of Care” section
    - If care is ongoing, prior goal status to show functional progress.
  - Plan of care, as detailed in the “Plan of Care” section
  - Initial evaluations must be performed at the start of care
  - Re-evaluations must be performed at a minimum annually to show ongoing functional delays, functional progress and provide evidence supporting medical necessity for the continuation of services.
- Clinical updates (such as a Progress Note, Updated Plan of Care or similar) at regular intervals or when additional care is requested, which includes:
  - Start of care date and total visits from the start of care
  - Current objective and outcome measures, with prior measures provided for comparison, and interpretation of results
  - Current level of function, with prior measures provided for comparison
  - Overall quantified progress toward each goal (including if the goal has or has not

- been met)
- Objective measures showing functional progress relative to each treatment goal as well as a comparison to the previous progress report
  - Measurable improvement and progress towards functional goals within an anticipated and reasonable timeframe toward a member's maximum potential.
  - Summary of member's response (or lack thereof) to intervention
    - If the member is not progressing, documentation of a revised plan of care is necessary, and must include specific barriers to progress.
  - Goals updated as appropriate
  - Requested frequency, duration and amount of care
    - Explanation of any significant changes in the plan of care and clinical rationale for why the ongoing skills of a PT/OT/ST are medically necessary for the frequency and duration of care requested.
  - Brief statement of the prognosis or potential for improvement in functional status
    - Any conditions that are impacting their ability to benefit from skilled intervention
  - Skilled treatment techniques that are being utilized
    - Evidence that the services are considered reasonable and effective treatments requiring the skills of a therapist.
  - Evidence of home program education provided to the member and/or caregivers
    - Development of an age-appropriate home program to facilitate carry-over of targeted skills and strategies as well as member, family, and caregiver education in home exercises and self-monitoring should be evident in the documentation
    - Indication of compliance of the home program should be documented to show maximum benefit of care
  - Evidence of discharge planning
  - Skilled services being provided by other community service agencies and/or school systems.
    - Services should not duplicate those being provided by community programs or agencies.
    - Document coordination of services with other agencies.
    - Document unavailable services.
  - For maintenance programs
    - Skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable.
    - Evidence that the specialized judgment, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services.

## Establishing a Delay or Deficit (7)

- Formal testing/functional assessments <sup>(6,8–11)</sup>
  - Age-appropriate, norm-referenced, standardized, and specific to the therapy provided <sup>(12,13)</sup>
  - Test scores and interpretation should establish the presence of a significant motor or functional delay as defined by the specific test
    - Raw scores are not sufficient to establish the presence of a delay
    - Score reports should include percentile ranks and/or standard deviations from the mean as applicable for the test used
  - While standardized testing is preferred, scores alone may not be used as the sole criteria for determining a member's medical need for skilled intervention
  - Test information must be linked to difficulty with or inability to otherwise perform everyday tasks
  - Orthopedic diagnoses not related to functional delay should include appropriate tests and measures specific to the deficit and the therapy provided
  - When standardized testing cannot be completed, the documentation must clearly state the reason formal testing could not be done
  - At a minimum, re-testing must occur yearly but may occur every 180 days
    - Providers must assess member status with the same testing instrument used in the initial evaluation or explain the reason for the change in testing instrument
- In the absence of standardized testing or when test scores show skills within normal ranges, the documentation must include one of the following:
  - Detailed clinical observations and objective data that clearly document the degree and severity of the functional deficits relative to the member's age
  - A caregiver interview/questionnaire that demonstrates functional deficits related to the member's age. This must also be supported by clinical observations or formal/informal assessment results
  - Informal assessment supporting Functional Mobility/ADL (Activities of Daily Living) deficits for the member's age and the medical need for skilled services
  - Swallowing disorders (dysphagia) and feeding disorders will need documentation of an oral, pharyngeal, and/or esophageal phase disorder, food intolerance, or aversion
    - Indications of a delay may include:
      - Gagging/choking
      - Documentation of an oral, pharyngeal, and/or esophageal phase disorder
      - Oral motor or upper extremity coordination deficits
      - Maladaptive behaviors due to food intolerance/aversion preventing adequate oral intake that contribute to malnutrition or decreased body mass index.

- If the delay is the result of fine motor, oral motor or sensory delays or deficits, testing and detailed clinical observations of oral motor skills should be included in the documentation, with each area addressed within the respective discipline's scope of practice
- Parent/caregiver report of limited food choices is not adequate to support the medical need for feeding therapy
- Evidence of ongoing progress and a consistent home program to facilitate carry-over of target feeding skills, strategies, and education of member, family, and caregiver
- Therapies are not medically necessary for picky eaters who:
  - Can eat and swallow normally
  - Meet growth and developmental milestones
  - Eat at least one food from all major food groups (protein, grains, fruits, etc.)
  - Eat more than 20 different foods

## Daily Notes

- Should include the following:
  - Clear evidence of skilled treatment interventions that cannot be conducted solely by non-skilled personnel. Assessment of member's response or non-response to intervention and plan for subsequent treatment sessions, assessments, or updates
  - Any significant, unusual, or unexpected changes in clinical status
  - A list of interventions which are unique and variable between treatment sessions
  - Any caregiver education or updates to the home program exercises or activities provided on that date of service

## Plan of Care (10,13,14)

- Evaluations, re-evaluations and clinical updates must include a plan of care that details the type, amount, duration, and frequency of therapy services required to achieve targeted outcomes
  - These must be consistent with accepted standards of practice and correspond with the member's medical and skilled therapy needs and level of disability
- The plan of care must include short and long-term functional goals that require skilled intervention and include all of the following:
  - SMART format: Specific, Measurable, Attainable, Relevant, and Timed <sup>(15)</sup>
  - Include the date the goal was established and the date the goal is expected to be met
  - Include the member's current status related to the goals

- For continuation of care, the status from prior assessment with date should be included to demonstrate progress over time
- Target the functional deficits identified during the assessment and promote attainment of age-appropriate developmental milestones, functional mobility, IADL (instrumental activities of daily living) and ADL skills, rest and sleep, play, social participation, functional communication skills, and/or feeding skills <sup>(12)</sup>
- Short and long-term functional goals **should NOT**:
  - Have underlying factors (such as performance skills, client factors, the environment, strength, range of motion, or cognition) as the sole focus
- The plan of care should include a reasonable anticipated timeframe to meet the established goals.
  - If goals are not met within the expected timeframe, documentation should explain why they were not met and if the plan of care was adjusted accordingly.
  - If the plan of care was not adjusted, documentation must demonstrate why the skills of a therapist are still medically necessary to address the goals.
  - If the member is not progressing, documentation of a revised treatment plan is necessary, and must address specific barriers to progress
- The plan of care must include interventions used to address these goals that are <sup>(12,13)</sup>:
  - Evidence-based, requiring the skills of a therapist to perform and/or teach the task.
  - Chosen to address the targeted goals.
  - Representative of the best practices outlined by the corresponding national organizations.
  - Considerate of functional limitations outlined in the most recent evaluation/assessment.
  - Promote motor learning or relatively permanent differences in motor skill capability that can be transferred and generalized to new learning situations.
  - Explicitly linked to the targeted goal/outcome they address.
  - Reinforced by the parents or other caregivers and can be practiced in the member's environment to sustain positive benefits <sup>(13)</sup>

## Special Considerations Related to Speech Therapy Diagnoses

- In the case of multilingual populations, considerations should be made to ensure assessment and interventions are culturally and linguistically appropriate.
  - When a member's language background differs from the rendering therapist and a clinician with native or near-native proficiency is not available, use of an interpreter is appropriate and should be documented accordingly along with a treatment plan that does not target second language influence <sup>(16)</sup>

- When language-matched multilingual service providers are not available, the clinician considers their own language skills in the target language, assesses the language needs of the member and family, and uses available resources to support language access. If a member is exposed to more than one language, the assessment must evaluate all language exposures and contain assessment tools that are culturally and linguistically adapted test equivalents in all languages is necessary to accurately distinguish between communication disorders and typical linguistic variations. <sup>(17)</sup>
- In the case of deficits or goals targeting reading/literacy, the notes must clearly indicate a primary diagnosis of a speech or language disorder.
  - Documentation must support that the deficits in reading/literacy are affecting functional activities of daily living and are not the primary focus of treatment. They must show how the services for reading/literacy are of such a complex nature that they require the skills of a speech-language pathologist.
- In the case of voice disorders, the notes must include evidence of an instrumental assessment completed by a specialized medical physician within an appropriate timeframe, in order to support the validity of the clinical findings and rule out any underlying medical causes or structural deficits. Any changes in function would warrant another physician's evaluation. <sup>(18,19)</sup>
- In the case of fluency disorders, the notes must provide evidence that stuttering is a medical condition and is no longer developmental in nature. <sup>(17)</sup>
- Treatment incorporating nonspeech oral motor exercises (NSOMEs) must be evidence based and paired with functional articulation and/or feeding/swallowing tasks. <sup>(20)</sup>

## Frequency and Duration <sup>(10,21–23)</sup>

- Must be supported by the level of skill required to address the goals stated in the plan of care and skilled treatment interventions, regardless of level or severity of delay.
- Must be commensurate with:
  - Member's level of disability
  - Medical and skilled therapy needs.
  - Accepted standards of practice
  - Clinical reasoning and current evidence
- Must include reasonable or anticipated timeframe to meet established goals
  - If goals are not met within the expected timeframe, documentation should explain why they were not met and if the plan of care was adjusted accordingly
    - If the plan of care is not adjusted, documentation must demonstrate why the skills of a therapist are still medically necessary to address the goals
- High and Intense frequencies
  - High and intense frequency care is not intended to be used for chronic care needs or

extended durations

- Intense frequencies (> 3 times per week) for a short duration (typically 4 weeks or less) will be considered on a case-by-case basis if all requirements for high-frequency are met AND clinical documentation clearly supports why 3 times per week therapy will not meet the client's medical needs
- High frequency (3x/week) for a short duration (typically 4 weeks or less) will be considered if a medical condition is rapidly changing (e.g. acute post-operative care, constraint induced movement therapy) and at least one of the following exceptional situations are documented:
  - Potential for rapid progress (e.g. excellent prognosis for skill acquisition)
  - Rapid decline or loss of functional skill (e.g. serious illness, recent surgery)
  - When the treatment plan is rapidly evolving, necessitating frequent updates to the home program
- If at least one of the preceding exceptional situations apply, ALL of the following documentation is required to qualify for high frequency care:
  - Recent testing (or objective, measurable clinical assessment) that supports a medical need to achieve an identified new skill or recover function
  - Specific, measurable and functional goals that will be achieved within the requested high-frequency period, including expected date of achievement
    - For ongoing care, documentation should show that goals previously set were achieved at a high frequency AND goals should be adjusted to demonstrate why care at 3 times per week is still needed
  - Clear explanation of why a higher frequency is more beneficial than a moderate or low frequency
- Moderate frequency (2x/week)
  - Therapy provided 2x/week may be considered when documents are consistent with at least moderate delays in age appropriate skills AND when documentation shows one or more of the following:
    - Member is making very good functional progress toward goals.
    - Member is in a critical period to gain new skills or restore function or is at risk of regression.
    - Licensed therapist needs to adjust the member's therapy plan and home program weekly or more often than weekly based on their progress and medical needs.
    - Each treatment session involves skilled and unique interventions that are not repetitive when compared to recent treatment sessions.
- Low frequency ( $\leq$  1x/week)
  - Therapy provided 1x/week or less may be considered when documents are consistent with mild delays in age-appropriate skills or when a higher frequency has

- not been clinically effective, and a similar outcome is likely with less treatment per week
- Low frequency is appropriate when:
    - Member is making progress toward their goals, but the progress has slowed.
    - Member is at risk of deterioration due to their medical condition.
    - Licensed therapist is required to adjust the patient's therapy plan and home program weekly to every other week based on the member's progress.
  - Every other week is appropriate when:
    - Medical condition is stable.
    - Member is making progress.
    - Anticipated member will not regress with every other week therapy.
  - Less than every other week is appropriate when:
    - The member cannot yet tolerate more frequent therapy sessions.
    - The member has needs that are addressed on a periodic basis as part of comprehensive management in a specialty clinic.
      - Occasional consultation may be appropriate to ensure gains continue, to address emerging concerns, or to help order equipment and train in its use.
  - Maintenance Level/Prevent Deterioration (e.g., every other week, monthly, every 3 months)
    - Is appropriate when:
      - Therapy plan changes very slowly
      - Home program is at a level that may be managed by the patient or the responsible adult/caregiver.
      - Therapy plan requires infrequent updates by the skilled therapist.
      - Progress has slowed or stopped and documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration.
      - Member may be making limited progress toward goals or that goal attainment is extremely slow.
      - Factors are identified that inhibit the member's ability to achieve established goals.
    - Documentation must show the following:
      - Habilitative plan of care has ended, and a new plan of care established for maintenance.
      - Goals in the plan of care must be updated to reflect that care is focused on maintaining the current level of functioning and preventing regression, rather than

progressing or improving function.

- Skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided.
- Member and responsible caregiver have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the member's needs.
- Specialized judgment, knowledge, and skills of a qualified therapist are required for the safe and effective performance of services.

## **Discontinuation of Treatment** (12,14,24–26)

A discharge plan must be included in the plan of care.

- The discharge plan must indicate the plan to wean services if:
  - Member has attained their goals.
  - Measurable, functional improvement over an anticipated and reasonable period of time has not been demonstrated.
  - Exercises and activities can be carried out by caregivers or other non-skilled personnel.
- Treatment can be discontinued if any of the following have been met:
  - The member returned to expected level of function or is able to perform functional skills at an age-appropriate level.
  - The member adapted to impairment with assistive equipment or devices.
  - The member is able to perform ADLs with minimal to no assistance from caregiver.
  - The member achieved maximum functional benefit from therapy.
  - The member will no longer benefit from additional therapy
  - The member is unable to participate in the treatment plan or plan of care due to:
    - Medical, psychological, or social complications
  - The caregiver received instructions on the home treatment program and is able to demonstrate independence with the program.
  - The skills of a therapist are not needed to provide or supervise the service.
  - Standardized testing shows they no longer have a developmental delay (as defined by the specific test used).
  - The member has reached a plateau in response to therapy or lack of significant progress towards therapy goals.
  - The member does not adhere to the plan of care including:
    - Poor attendance of member or responsible caregiver

- With therapy treatment and home treatment program
  - Treatment ceases to be of therapeutic value.
- Skilled care may be appropriate to resume after discharge if the member shows signs of regression in function despite a comprehensive home program. Periodic episodes of care may be needed over a lifetime to address specific needs or changes in condition resulting in functional decline.

## CODING AND STANDARDS

### Applicable Lines of Business

☒	CHIP (Children’s Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

## SUMMARY OF EVIDENCE

### Standards of Practice for Occupational Therapy <sup>(4)</sup>

Casto et al. provides comprehensive standards and guidelines for occupational therapy practice. Key points include:

- **Standards of Practice:**
  - Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non-disability-related needs. These services include the acquisition and preservation of occupational identity for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.
- **Education, Examination, and Licensure Requirements:**
  - All occupational therapists and occupational therapy assistants must practice within compliance with federal and state laws. They must have graduated from an accredited program, completed supervised fieldwork, passed a nationally recognized entry-level examination, and fulfilled state requirements for licensure, certification, or registration.

- **Service Delivery:**
  - Occupational therapy practitioners provide skilled services through direct (in-person, group sessions, telehealth) and indirect (consultation, advocacy) approaches. They are responsible for ensuring client safety and continually evaluating the effectiveness of therapy processes.
- **Screening, Evaluation, and Reevaluation:**
  - Occupational therapists are responsible for all aspects of the screening, evaluation, and reevaluation process. They collaborate with clients to complete occupational profiles and analyze performance to identify needs, supports, and barriers. They use evidence-based, standardized assessment tools and protocols.
- **Intervention Process:**
  - Occupational therapists develop, document, and implement intervention plans based on evaluations, client goals, best available evidence, and professional reasoning. They collaborate with clients and other professionals to facilitate engagement in occupation and modify plans as needed.
- **Outcomes, Transition, and Discontinuation:**
  - Occupational therapists determine outcomes, implement and interpret outcome measures, and document progress. They are responsible for transitioning clients to other services or discontinuing services when goals are met or clients no longer wish to continue.

### **Occupational Therapy Practice Framework: Domain and Process—Fourth Edition** <sup>(12)</sup>

The Occupational Therapy Practice Framework: Domain and Process (4<sup>th</sup> Edition) emphasizes the importance of a client-centered approach, where therapy is tailored to the individual's needs, preferences, and goals. It highlights the significance of using evidence-based practices to ensure the effectiveness and efficiency of therapy interventions. The recommendations include:

- **Assessment and Evaluation:** Conduct thorough assessments to understand the client's needs, strengths, and areas of improvement. This includes evaluating their physical, cognitive, and emotional status.
- **Individualized Treatment Plans:** Develop personalized treatment plans that address the specific needs and goals of the client. This involves selecting appropriate therapeutic activities and interventions that promote engagement and participation in meaningful occupations.
- **Interdisciplinary Collaboration:** Collaborate with other healthcare professionals to provide holistic care. This includes working with physical therapists, speech therapists, and other specialists to ensure comprehensive treatment.
- **Client and Family Education:** Educate clients and their families about the therapy process, expected outcomes, and ways to support the client's progress at home. This helps in creating a supportive environment for the client.

- **Outcome Measurement:** Regularly measure and document the client's progress using standardized outcome measures. This helps in evaluating the effectiveness of the therapy and making necessary adjustments to the treatment plan.
- **Use of Technology:** Incorporate assistive technology and adaptive equipment to enhance the client's independence and participation in daily activities. This includes using devices that support mobility, communication, and self-care.
- **Focus on Functional Goals:** Set functional goals that are relevant to the client's daily life and activities. This ensures that the therapy is practical and directly impacts the client's quality of life.
- **Continuous Professional Development:** Stay updated with the latest research and advancements in therapy practices. This involves participating in continuing education and professional development opportunities.

## ANALYSIS OF EVIDENCE

### Shared Conclusions <sup>(4,12)</sup>:

- **Definition and Scope of Occupational Therapy:** Both articles define occupational therapy as the therapeutic use of everyday life occupations to enhance or enable participation for clients with disability and non-disability-related needs. They emphasize the importance of addressing physical, cognitive, psychosocial, and sensory-perceptual aspects of clients' performance to support their engagement in occupations that affect physical and mental health, well-being, and quality of life.
- **Client-Centered Approach:** Both documents highlight the importance of a client-centered approach in occupational therapy. They stress the need for practitioners to collaborate with clients to develop and implement intervention plans that address the clients' needs, priorities, and goals.
- **Standards and Guidelines:** Both articles provide standards and guidelines for occupational therapy practice. They outline the responsibilities of occupational therapists and occupational therapy assistants, including maintaining licensure, adhering to ethical standards, and using evidence-based practices.

## POLICY HISTORY

Date	Summary
December 2025	<ul style="list-style-type: none"> <li>● This guideline merges and replaces the following guidelines:               <ul style="list-style-type: none"> <li>○ ECG 1505 for Outpatient Habilitative and Rehabilitative Speech Therapy</li> <li>○ ECG 1506 for Outpatient Habilitative Physical and Occupational Therapy</li> </ul> </li> </ul>

## LEGAL AND COMPLIANCE

### Guideline Approval

#### Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

### Disclaimer

*Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.*

*Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.*

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# Evolut Clinical Guideline 1510 for Record Keeping and Documentation Standards: Physical Medicine

<b>Guideline Number:</b> Evolut_CG_1510		
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# STATEMENT

## General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

## Purpose

This guideline will assist the physical therapist, occupational therapist, and/or speech-language pathologist in creating and maintaining complete and appropriate clinical records and documentation.

All recommendations in this guideline reflect practices that are evidence-based and/or supported by broadly accepted clinical specialty standards.

## Scope

All network practitioners will maintain clinical documentation that clearly supports the medical necessity of all health care services. In addition, all network practitioners are required to provide additional clinical documentation and/or explanation regarding medical necessity of services at the request of this organization.

These guidelines apply to all markets and populations, including teletherapy, contracted with this organization through the corresponding state health plans unless a market-specific health plan has been developed.

To be covered, documentation must contain evidence to support medical necessity and the need for skilled services as appropriated by the following descriptions and definitions.

## Special Note

Recordkeeping is used to document the condition and care of the patient (member), avoid or defend against a malpractice claim, and support the concurrent and/or retrospective medical necessity requiring the provision of skilled services. The provider is responsible for documenting the evidence to clearly support the foregoing indices and submitting the documentation for review in a timely manner.

## MEDICAL RECORD CONTENT REQUIREMENTS <sup>(1-3)</sup>

### General Guidelines

- Documentation should clearly reflect why the skills of a practitioner are needed and why the care is **medically necessary**
- All records (both digital and handwritten) must be legible: the ability of at least two people to read and understand the documents.
- Documentation should be complete and include:
  - Practitioner's signature and credentials
  - Appropriately dated chart entries
  - Member identifications on each page
- Corrections to the member's record must be made legibly in permanent ink (single line through the error), dated, and authenticated by the person making the correction(s)
  - Electronic documentation should include the appropriate mechanism indicating that a change was made without the deletion of the original record.
- Services must be documented in accordance with Current Procedural Terminology (CPT®) coding criteria (e.g., location (body region), time component, etc.)
- Adverse events associated with treatment should be recorded in the member chart.

### Evaluation/Re-Evaluation

Initial evaluations and re-evaluations including plan of care (**see below**) must be performed by a state-licensed physical therapist (PT), occupational therapist (OT), or speech-language pathologist (SLP) and/or if applicable, a doctor of medicine (MD), doctor of osteopathic medicine (DO) or doctor of podiatric medicine (DPM) and should document:

- Medical need for a course of treatment through objective findings and subjective self or caregiver reporting
- Pertinent history and general demographics including
  - Past or current treatment for the same condition including the discharge note or summary of recently completed care
  - Baseline evaluation including current and prior functional status (submit for review)
  - The need for continual treatment or ongoing care for multiple diagnoses is not typical <sup>(4)</sup>
    - Documentation must clearly show why recurring episodes of care are needed
    - It is expected that education from prior care would help with management of new conditions
- Copy of discharge summary including a written letter from the member stating when services ended or a specific reference to the date the member chose to end care with a

prior provider must be provided if member has a current authorization with a different provider and is seeking services with a new provider.

- Treatment should not duplicate services provided in multiple settings or disciplines.
- Impact of the conditions and complexities on the prognosis and/or the plan for treatment such that it is clear to the peer reviewer that the planned services are reasonable and appropriate for the individual.
- Objective measures and/or discipline-specific standardized testing that demonstrates delays that are connected to a decline in functional status must be provided.
  - Assessment tools used during the evaluation should be <sup>(1)</sup>:
    - Valid
    - Reliable
    - Relevant to the condition(s) being addressed
    - Supported by the appropriate national therapy best practices guidelines.
  - Scores alone may not be used as the sole criteria for determining a member's medical need for skilled intervention.
    - Test information must be linked to difficulty with/inability to perform everyday tasks.
- In the absence of objective measures, the report must include:
  - Detailed clinical observations of current skill sets
  - Member or caregiver interview/questionnaire and/or informal assessment supporting functional mobility, activities of daily living (ADL), instrumental activities of daily living (IADL), health management, rest and sleep, and/or social participation deficits.
  - Medical need for skilled services
  - The reason formal testing could not be completed.
- Functional outcome assessment and/or standardized test results to include:
  - Raw scores
  - Standardized scores
  - Score interpretation
- Detailed clinical observation, prognosis, and rehab potential must be outlined.
- Contraindications to care must be listed with an explanation of their current management.

## Daily Notes

1-2 daily notes, or the treatment log, should be provided with each request to show skilled treatment interventions and should include the following:

- Clear evidence of skilled treatment interventions that cannot be conducted solely by non-

skilled personnel.

- Assessment of member's response or non-response to intervention and plan for subsequent treatment sessions, assessments, or updates
- Any significant, unusual, or unexpected changes in clinical status
- Interventions that show skilled care and are unique and not repetitive when compared to recent treatment sessions

## Treatment Plan or Plan of Care

The plan of care should clearly support why the skills of a professional are needed as opposed to discharge to self-management or non-skilled personnel without the supervision of qualified professionals. .

The plan of care should include the following:

- Meaningful clinical observations
- Member's response to the evaluation process
- Interpretation of the evaluation results including:
  - Prognosis for improvement
  - Recommendations for therapy services amount, frequency, and duration
  - Any barriers to a typical course of treatment
- Short and long-term goals that require skilled interventions to achieve targeted outcomes
  - SMART (Specific, Measurable, Attainable, Realistic, and Time-bound)
  - Detail the type of intervention that must be:
    - Skilled treatment interventions, regardless of level of severity of deficit or delay
    - Evidence-based
    - Chosen to address the targeted goals and/or outcomes.
    - Representative of the best practices outlined by the corresponding national organizations.
  - Amount, duration, and frequency
    - The frequency and duration must be commensurate with:
      - Member's level of disability
      - Medical and skilled therapy needs
      - Accepted standards of practice
      - Clinical reasoning and current evidence
      - Level of skill needed to address the goals in the plan of care
      - Frequency and duration of skilled services must also be in accordance with

the following <sup>(5-7)</sup>:

- ◆ Intense frequencies ( $\geq 3x/\text{week}$ ) require additional documentation and testing to support a medical need (achieve an identified new skill or recover a function with specific, achievable goals within the requested period)
  - ◇ Include details on why a higher frequency is more beneficial than a moderate or low frequency.
  - ◇ Higher frequencies may be considered when deficits are classified as severe (indicated by corresponding objective measures and/or testing guidelines used in the evaluation)
  - ◇ More intensive frequencies may be necessary in the acute phase (progressive decline in frequency is expected within a reasonable time)
- ◆ Moderate frequency (2x/week) should be consistent with moderate deficits (established by objective measures and/or the general guidelines of formal assessments in the evaluation)
  - ◇ Frequency may be used for ongoing care when documentation supports it as being clinically effective toward achieving the functional goals in the treatment plan within a reasonable time.
- ◆ Low frequency (1x/week or every other week) may be considered when objective measures and/or testing guidelines indicate mild deficits, when a higher frequency has not been clinically effective, or when a slower rate of progress is expected, and a similar outcome is likely with less treatment per week
  - Visits or units requested must not exceed the frequency and duration documented in the plan of care.
    - Linked to functional limitations outlined in the most recent valuation or assessment.
    - Additional factors may be considered on a case-by-case basis.
- Expected caregiver involvement in the member's treatment
- Educational plan, including:
  - Home exercises
  - Activities of Daily Living (ADL) modifications
  - Anticipated discharge recommendations including:
    - Education of the member in a home program
    - Primary caregiver education (when applicable)
- Anticipated discharge planning should be included in plans of care; formal discharge from care should be considered when:
  - Records demonstrate services are unskilled or could be completed as part of a home program.

- Functional limitations do not support the rate of care requested (stated above)
- Treatment is provided without a treatment plan, functional goals, or recent, sustained improvement.
- Plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third-party requirements. This review should include:
  - Total visits from the start of care
  - Changes in objective measures
  - Updated outcome measure scoring and interpretation of results
  - Overall quantified progress towards each goal (including if goal has been met or not met)
  - Modification of treatment interventions needed to meet goals.
  - Goals updated as appropriate.
  - Summary of a member's response (or lack thereof) to intervention
  - Statement (brief) of the prognosis or potential for improvement in functional status
  - Updates to the frequency or amount of expected care based on the level of skill required to address the current goals, progress made/lack of progress, or in preparation for discharge

**Note:** Treatment must not be focused on returning to activities beyond normal daily living, including but not limited to return to sports, recreational activities, and/or work-specific tasks.

## Maintenance Care

Maintenance level of therapy services may be considered when a member requires skilled therapy for ongoing periodic assessments, consultations, and treatment.

- Goals in the plan of care must reflect that care is focused on maintaining the current level of function and preventing regression rather than progressing or improving function.
- Clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided.
- The documentation must clearly demonstrate that the specialized judgement, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.
- It is expected that evidence will be provided regarding the implementation of a comprehensive home program with indications of compliance by the member to the home program for maximum benefit of therapy.

## Lack of Information

Reviewers can determine whether claims or requests have insufficient documentation when the medical documentation submitted is inadequate to support a request for services as medically

necessary or requiring skilled services for the requested amount of care. Incomplete notes (e.g., unsigned, undated, and insufficient detail showing clear evidence supporting recent significant progress with treatment, such as lacking baseline/updated objectives and goals, or specific plan of care) may result in denial for lack of sufficient information.

## Confidentiality of Records

All contracted practitioners will treat member identifiable health information according to HIPAA standards to ensure the confidentiality of the record and provide the minimum necessary information when requested to perform a review of services.

## CODING AND STANDARDS

### Applicable Lines of Business

☒	CHIP (Children’s Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

## BACKGROUND

### Medical Necessity (1,2,8)

Medically necessary services are reasonable or necessary services that require the specific training, skills, and knowledge of a physical or occupational therapist and/or speech/language pathologist to diagnose, correct, or significantly improve/optimize as well as prevent deterioration or development of additional physical health conditions. These services require a complexity of care that can only be safely and effectively performed by or under the general supervision of a licensed practitioner.

- Services shall not be considered reasonable and medically necessary if:
  - They can be omitted without adversely affecting the member’s condition or their quality of care.
  - Simply because a licensed practitioner furnishes it.
    - If a service can be self-administered or safely and effectively conducted by an unskilled person, without the direct supervision of a practitioner, then it cannot be regarded as a skilled service even though a licensed practitioner rendered the

service.

- The unavailability of a competent person to provide a non-skilled service resulting in the non-skilled service being rendered by a licensed practitioner does not make the service provided a skilled service.
- They include repetitive activities (exercises, skill drills) which do not require a licensed practitioner's expertise (knowledge, clinical judgment and decision-making abilities) and can be learned and performed by the patient or caregiver.
- They are activities for general fitness and flexibility, sports-specific training enhancement or general tutoring for improvement in academic performance.

Medically necessary care must be:

- **Contractual** – all health care services are determined by the practitioner's contract with the payer and individual health plan benefits.
- **Within Scope of Practice** – all health care services are limited to the scope of practice under all applicable state and national health care boards.
- **Within Standard of Practice** – all health care services must be within the practitioner's generally accepted standard of practice.
- **Considerate of Patient Safety** – all health care services must be delivered in the safest possible manner.
- **A Medical Service** – all health care services must be medical, not social or convenient for the purpose of evaluating, diagnosing, and treating an illness, injury, or disease and its related symptoms and functional deficit.
  - These services must be appropriate and effective regarding type, frequency, level, duration, extent, and location of the enrollee's diagnosis or condition.
- **Considerate of Setting** – all health care services must be delivered in the least intensive setting.
- **Considerate of Cost** – the practitioner must deliver all health care services in the most cost-effective manner as determined by this organization, the health plan, and/or employer.
  - No service should be more costly than an alternative diagnostic method or treatment that is at least as likely to provide the same diagnostic or treatment outcome.
- **Supported by Clinical Guidelines** – health care services meet all of the Clinical Guidelines of this organization.

## SUMMARY OF EVIDENCE

### Occupational Therapy Practice Framework: Domain and Process—Fourth Edition <sup>(1)</sup>

The Occupational Therapy Practice Framework: Domain and Process—Fourth Edition provides comprehensive guidelines on record keeping and documentation standards for occupational therapy practitioners. Here are the key points:

- **Purpose and Importance:** They emphasize that accurate and thorough documentation is essential for effective communication among healthcare providers, continuity of care, and legal protection. They also support reimbursement and quality improvement efforts.
- **Standards and Guidelines:** The framework outlines specific standards for documentation, including the need for clarity, accuracy, and timeliness. Documentation should reflect the practitioner's clinical reasoning, the client's progress, and the outcomes of interventions.
- **Types of Documentation:** Various types of documentation are discussed, such as initial evaluations, progress notes, discharge summaries, and treatment plans. Each type has specific requirements and should be tailored to the client's needs and the context of the service provided.
- **Confidentiality and Security:** They also highlight the importance of maintaining client confidentiality and securing records. Practitioners must comply with legal and ethical standards to protect client information.
- **Recommendations for Best Practices:** The framework provides recommendations for best practices in documentation, including using standardized terminology, being concise yet comprehensive, and regularly reviewing and updating records. It also suggests using electronic health records (EHRs) to enhance efficiency and accessibility.
- **Legal and Ethical Considerations:** Practitioners are advised to be aware of and adhere to relevant laws and regulations governing documentation. This includes understanding the requirements for record retention and the potential legal implications of documentation practices.

#### Documentation in health care <sup>(2)</sup>

- **Overview:** Documentation is essential for conveying clinical information about a patient's diagnosis, treatment, and outcomes. It should answer questions about the medical necessity of services, their relevance, and their value to the patient's care.
- **Documentation Principles:** Documentation should justify the need for evaluation and treatment services, following guidelines such as those from Medicare. It should be clear, legible, and efficiently convey essential information.
- **Medical Necessity:** Justifying medical necessity involves demonstrating that services are reasonable, necessary, specific, effective, and skilled. Relevant documentation includes medical history, diagnosis, treatment plans, progress notes, and status reports.
- **Skilled Services:** Services eligible for reimbursement must require the expertise and clinical judgment of a qualified health care professional. SLPs should document their analysis, design, delivery, modification, and engagement in treatment.
- **Billing and Insurance:** Proper documentation is crucial for obtaining reimbursement. It should justify the billing codes used and align with guidelines from systems like HCPCS and ICD.
- **Medicare and Medicaid:** Medicare and Medicaid have specific documentation requirements, including evaluations, treatment plans, progress reports, and discharge summaries. Private insurance documentation should follow similar principles.

- **Components of Documentation:** Documentation must be signed, dated, and include the clinician's credentials. It should detail clinical interactions, therapy types, and any accommodations or modifications made.
- **Types of Documentation:** Different types of documentation include evaluation reports, treatment notes, progress notes, and discharge summaries. Each type has specific elements that should be included.
- **Ethical and Legal Issues:** Documentation must be accurate and timely, following ethical guidelines and legal standards. Changes to documentation should be properly noted and signed.
- **HIPAA and Record Retention:** HIPAA regulations ensure the confidentiality and security of patient information. Record retention laws vary by state and setting, and clinicians should follow the most stringent regulations.

### **Chapter 15 Covered Medical and Other Health Services - 220.3 - Documentation Requirements for Therapy Services <sup>(8)</sup>**

- **General Requirements:** Medical records must be complete and legible. They should include the patient's name, date of service, and the identity of the provider. Documentation must support the medical necessity and appropriateness of the services provided.
- **Content of Records:** Records should contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment. This includes history and physical exams, progress notes, and results of diagnostic tests.
- **Specific Documentation Requirements:** For certain services, specific documentation is required. For example, for home health services, the plan of care must be documented and signed by the physician. For durable medical equipment, the necessity and use of the equipment must be documented.
- **Electronic Health Records (EHRs):** EHRs must meet the same standards as paper records. They should be secure, accessible only to authorized personnel, and include an audit trail to track access and changes.
- **Retention of Records:** Records must be retained for a minimum of five years from the date of service. This period may be extended if required by state law or other regulations.
- **Confidentiality and Security:** Patient information must be kept confidential and secure. This includes physical security measures for paper records and technical safeguards for electronic records.

## ANALYSIS OF EVIDENCE

### Shared Conclusions <sup>(1,2,8)</sup>:

- **Importance of Documentation:**
  - All three documents emphasize the critical role of documentation in healthcare. The CMS Regulations and Guidance Manual highlights the necessity of maintaining accurate records for Medicare compliance. The ASHA document underscores the importance of clear and thorough documentation to justify the medical necessity of services and ensure effective communication among healthcare providers. Similarly, the OT Practice Framework stresses the significance of documentation in supporting occupational therapy interventions and outcomes.
- **Compliance with Regulations:**
  - Each document stresses the need for compliance with federal and state regulations. The CMS manual provides detailed guidelines on Medicare documentation requirements. The ASHA document mentions the need to adhere to state and federal requirements, especially when they are more stringent than those of facilities or payers. The OT Practice Framework also acknowledges the importance of following regulatory standards to ensure the quality and legality of occupational therapy services.
- **Client-Centered Approach:**
  - All three documents advocate for a client-centered approach to documentation. The ASHA document emphasizes the need to document services that are tailored to the individual needs of the patient. The OT Practice Framework highlights the importance of understanding the client's perspective and incorporating their values and priorities into the documentation process. The CMS manual also supports the idea of documenting services that are specific to the patient's condition and needs.

## POLICY HISTORY

Date	Summary
December 2025	<ul style="list-style-type: none"> <li>● Added second bullet in General Information section</li> <li>● Updated the following sections:               <ul style="list-style-type: none"> <li>○ Evaluation/Re-Evaluation</li> <li>○ Daily Notes</li> </ul> </li> <li>● Added a Summary of Evidence and Analysis of Evidence</li> </ul>
November 2024	<ul style="list-style-type: none"> <li>● This guideline replaces Evolent Clinical Guideline 606-01 for Record Keeping and Documentation: Physical Medicine</li> <li>● Updated references</li> </ul>



## LEGAL AND COMPLIANCE

### Guideline Approval

#### Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

#### Disclaimer

*Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.*

*Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.*

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# Evolut Clinical Guideline 1501 for Chiropractic Infant Care Policy

<b>Guideline Number:</b> Evolut_CG_1501		
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<b>Original Date:</b> April 2016	<b>Last Revised Date:</b> December 2025	<b>Implementation Date:</b> July 2026

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## STATEMENT

### General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

### Purpose

Support medically necessary, appropriate, and acceptable chiropractic treatment of infants (age: birth to 24 months).

### Special Note

The evaluation, diagnosis, and management of infants falls within the scope of chiropractic practice.

**NOTE:** Chiropractic providers should not engage in unsafe or unproven services as outlined in this policy. There is insufficient evidence that manual therapy (spinal manipulation, extraspinal manipulation, and mobilization) results in improved health outcomes, particularly functional outcomes, related to the treatment of both musculoskeletal and non-musculoskeletal infant conditions. <sup>(1)</sup>

### Scope

This guideline applies to all physical medicine participating network practitioners.

## INDICATIONS

**ALL** of the following apply:

- Therapeutic trial of chiropractic care for the infant patient <sup>(2)</sup>:
  - In the absence of conclusive evidence, clinical experience and patient/parent preferences must align
  - If the infant patient shows no clinically significant improvement (progress toward measurable goals) after a trial period of chiropractic care, no additional chiropractic care is indicated, and referral may be appropriate
- Manual-based therapy (spinal/extraspinal manipulation and mobilization), active care, and passive therapies have not been shown to improve the health outcomes of spine,

extremity-based musculoskeletal conditions, or non-musculoskeletal conditions (childhood immunizations, treatment of infectious diseases, etc.) in infant populations <sup>(3)</sup>

- There is no contemporary chiropractic consensus demonstrating a general agreement to support the treatment of non-musculoskeletal conditions, <sup>(4)</sup> such as:
  - Treatment of the common cold
  - Sinus congestion
  - Allergies
  - Sleep disturbances
  - Difficulty nursing
  - Infantile colic
  - Attention deficit hyperactivity disorder (ADHD)
  - Asthma
  - Autism
  - Cerebral palsy
  - Constipation
  - Nocturnal enuresis
  - Otitis media
  - Chiropractic infant care for wellness care, well-baby checks, and preventive care are **NOT** covered
  - The use of maintenance or preventive spinal/extraspinal manipulation (see **Background**)

**NOTE:** This organization has the decisive authority to determine if treatment is medically necessary and appropriate.

## CODING AND STANDARDS

### Applicable Lines of Business

☒	CHIP (Children’s Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

## BACKGROUND

Preventive, defined as prevention of any disease or condition or the promotion and enhancement of health after maximum therapeutic benefit has occurred.

### Literature Support

As of August 15, 2023, there is no first-level, evidence-based literature in relation to the effectiveness of manual therapy/manipulation for spinal disorders in the infant (young) population. <sup>(4,5)</sup>

### Infantile Colic

In the American Academy of Family Physicians (AAFP) report on infantile colic, one of the primary levels of treatment is parental reassurance and support because colic is benign. <sup>(6)</sup> Although the AAFP article addresses physical therapies for colic, which included chiropractic and osteopathic manipulation, massage, and acupuncture, there is insufficient evidence to support these therapies. <sup>(4)</sup>

### Non-musculoskeletal

The American Academy of Pediatrics clinical report on Pediatric Integrative Medicine corroborates there is a lack of quality evidence to support the effectiveness of spinal manipulation for non-musculoskeletal conditions in infants and children in which the risks of adverse events may be the highest because of immature stability of the spine or high-velocity extension and rotational spinal manipulation. <sup>(3)</sup>

### Musculoskeletal

No high-quality methodological guidelines, systematic reviews, or randomized controlled trials were discovered in a literature search regarding the treatment of infant musculoskeletal conditions with spinal or extra-spinal manipulation, mobilization, massage therapy, mechanical traction, electrical stimulation, ultrasound therapy, or low-level laser therapy (LLLT).

## SUMMARY OF EVIDENCE

### Clinical Practice Guideline for Best Practice Management of Pediatric Patients by Chiropractors: Results of a Delphi Consensus Process <sup>(2)</sup>

Keating et al. highlight that chiropractic care for infants is primarily sought for musculoskeletal conditions, but it is also used for developmental concerns. The evidence indicates that adverse events associated with chiropractic care for children are very rare. A 2023 retrospective analysis of 54,846 patients found no adverse events in children. They also emphasizes the importance of modifying chiropractic techniques to accommodate the unique anatomical and physiological characteristics of infants. This includes using gentler and lighter manual procedures and ensuring the safety of the developing skeleton. While there is a lack of definitive evidence for the effectiveness of chiropractic care for specific conditions in infants, the practice is generally considered safe when performed by trained professionals.

### **Pediatric Integrative Medicine** <sup>(3)</sup>

The evidence supporting chiropractic care for infants is primarily focused on musculoskeletal issues. Chiropractic care is commonly used for infants and children for a variety of concerns, including colic, sleep disturbances, and musculoskeletal problems. However, high-quality evidence supporting the effectiveness of spinal manipulation for non-musculoskeletal concerns in infants and children is lacking. The risks of adverse events may be higher in infants due to the immature stability of their spine. McClafferty et al. also highlights the importance of conducting a thorough history and physical examination to exclude any abnormal anatomic or neurologic findings before using any type of manual or manipulative therapy on a child.

### **Manual therapy for the pediatric population: a systematic review** <sup>(4)</sup>

Parnell Prevost et al 2019 Manual Therapy for the pediatric population a systematic review" provides a comprehensive review of the evidence supporting chiropractic care for infants. Here are the key points:

- **Infantile Colic:** The evidence for chiropractic care in treating infantile colic is mixed. Some studies show improvement in symptoms, while others do not. Overall, the evidence is inconclusive.
- **Constipation:** The evidence for chiropractic care in treating constipation in infants is unclear.
- **Low Back Pain:** There is moderate positive evidence supporting chiropractic care for low back pain in adolescents, but this is less relevant for infants<sup>1</sup>.
- **Otitis Media:** The evidence for chiropractic care in treating otitis media (ear infections) is inconclusive.
- **Asthma:** The evidence for chiropractic care in treating asthma in children is mixed and inconclusive.
- **Scoliosis:** The evidence for chiropractic care in treating scoliosis in children is unclear and generally unfavorable.

## **ANALYSIS OF EVIDENCE**

### **Shared Conclusions** <sup>(2-4)</sup>

- **Safety and Adverse Events:** All three articles agree that adverse events related to chiropractic care in infants are rare and generally mild. The studies emphasize the importance of safety and the need for thorough assessments to avoid potential risks. For instance, Parnell Prevost et al. notes that adverse events were uncommonly reported and were transient and mild to moderate in severity. Similarly, Keating et al. highlights that adverse events are very rare in children receiving chiropractic manipulation
- **Effectiveness for Specific Conditions:** The articles share a consensus on the effectiveness of chiropractic care for certain conditions. For example, Parnell Prevost et al. found moderate-positive overall assessments for conditions like low back pain and pulled elbow. McClafferty et al. also acknowledges the use of chiropractic manipulation

for musculoskeletal conditions. Keating et al. supports the use of chiropractic care for musculoskeletal issues, emphasizing the need for evidence-based practice.

- **Need for Further Research:** All three articles stress the need for more robust clinical trials and research to establish the effectiveness and safety of chiropractic care for various pediatric conditions. Parnell Prevost et al. calls for more robust clinical trials, while McClafferty et al. and Keating et al. both highlight the importance of ongoing research to fill the gaps in current knowledge.

## POLICY HISTORY

Date	Summary
December 2025	<ul style="list-style-type: none"> <li>● Added second bullet in General Information section</li> <li>● No significant clinical changes</li> <li>● Added a Summary of Evidence and Analysis of Evidence</li> </ul>
November 2024	<ul style="list-style-type: none"> <li>● This guideline replaces Evolent_CG_611 Chiropractic Infant Care Policy</li> <li>● CPT Codes removed from the Indications section. The CPT Codes section in Coding was also removed</li> <li>● Editorial changes to match the formatting and layout of the Evolent template</li> <li>● Edited the 'Infantile Colic' section of the Background to make it more concise</li> <li>● Updated references</li> </ul>

## LEGAL AND COMPLIANCE

### Guideline Approval

#### *Committee*

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee



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# Evolut Clinical Guideline 1509 for Record Keeping and Documentation Standards: Chiropractic Care

<b>Guideline Number:</b> Evolut_CG_1509		
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## STATEMENT

### General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

### Purpose

This guideline will assist the chiropractor in creating and maintaining complete and appropriate clinical records and documentation.

All recommendations in this guideline reflect practices that are evidence-based and/or supported by broadly accepted clinical specialty standards.

## MEDICAL RECORD CONTENT REQUIREMENTS

### General Guidelines <sup>(1,2)</sup>

- Documentation should clearly reflect why the skills of a licensed chiropractor are needed/the care is **medically necessary**
- All records (both digital and handwritten) must be legible
  - The ability of at least two people to read and understand the documents.
- Each date of service must adequately identify the patient and include the treating chiropractor's signature and credentials. Each subsequent page must also contain:
  - The patient's name or ID number
  - The subjective complaint(s)
  - Objective findings, assessment
  - Diagnosis, treatment/ancillary diagnostic studies performed
  - Any recommendations, instructions, or patient education
- All chart entries must be dated with the month, day, and year
- Handwritten records
  - In chronological order and in permanent ink with original signatures
- Electronic entries

- Use appropriate security and confidentiality provisions
- Patient demographics including all of the following:
  - Name
  - Address
  - Telephone numbers (home and work)
  - Gender
  - Date of birth
  - Occupation
  - Marital status
- Working diagnosis(es) or condition description similar to the appropriate International Classification of Diseases (ICD) code
  - If the ICD code is not applicable/allowed, it must be documented and consistent with the associated findings.
- Reason for the encounter or referral (i.e., presenting complaint(s))
- Services must be documented in accordance with Current Procedural Terminology (CPT®) coding criteria (e.g., location (body region), time component, etc.)
- Adverse events associated with treatment should be recorded in the patient chart
- Copies of:
  - Relevant reports and correspondence with other skilled practitioners
    - Diagnostic studies
    - Laboratory findings
    - Consultations
  - Reports and correspondence related to treating chiropractor's diagnostic studies
    - Laboratory findings
    - Consultations including
      - Rationale for the service
      - Rationale for consult and findings
      - Conclusions
      - Recommendations
- Copy of discharge if patient has a current authorization with a different provider and is seeking services with a new provider
  - Treatment should not duplicate services provided in multiple settings.
- Appropriate consent forms should be included when applicable
- A key or summary of terms when non-standard abbreviations are used.

- Any corrections to the patient's record must be made legibly in permanent ink (single line through the error), dated, and authenticated by the person making the correction(s)
  - Electronic documentation should include the appropriate mechanism indicating that a change was made without the deletion of the original record

## Evaluation <sup>(1,2)</sup>

The evaluation documentation must include:

- Support the medical need for a course of treatment through:
  - Objective findings
  - Detailed clinical observations
  - Subjective self-reporting
- Patient's prior medical, familial, and social history
- Baseline evaluation
  - Current and prior functional status (functional mobility and activities of daily living (ADL) deficits)
- Systems review consistent with the nature of the complaint(s) and relevant historical information
- Objective measures and/or standardized orthopedic and neurological testing demonstrating a decline in functional status
  - Assessment tools used during the evaluation should be valid, reliable, relevant, and supported by appropriate chiropractic best practices guidelines
  - While outcome assessment measures are preferred, scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention; test information must be linked to difficulty with or inability to perform everyday tasks
- In the absence of objective measures, the evaluation must include:
  - Detailed clinical observations of current skill sets
  - Patient interview/questionnaire, and/or informal assessment supporting functional mobility/ADL deficits
  - Medical need for skilled services
  - The reason formal testing could not be completed
- Functional outcome assessment and/or standardized test results with:
  - Raw scores
  - Standardized scores
  - Score interpretations
- Prognosis and rehab potential

## Treatment Plan/Plan of Care <sup>(2,3)</sup>

Plan of care must be individualized, goal-oriented, and aimed at restoring specific functional deficits.

**NOTE:** Treatment must not be focused on returning to activities beyond normal daily living.

The plan of care should clearly support why the skills of a licensed chiropractor are needed as opposed to discharge to self-management or non-skilled personnel without the supervision of a licensed chiropractor. If telehealth is included, the plan of care should clearly support why the skills of a licensed chiropractor are needed as opposed to discharge to self-management or non-skilled personnel without the supervision of a licensed chiropractor.

### ***Plan of care elements***

- The patient's age and date of birth
- Date of evaluation
- Medical history and background
- All diagnoses related to the patient's condition
- Contraindications to treatment
- Safety risks
- Date of onset or current exacerbation of the patient's condition
- Description of baseline functional status/limitations based on standardized testing administered or other assessment tools
- Patient's response to the evaluation process and interpretation of the evaluation results
- Prognosis for improvement
- Recommendations for the amount, frequency, and duration of services must:
  - Include what is required to achieve targeted outcomes
  - Be commensurate with the patient's level of disability
  - Demonstrate accepted standards of practice
  - Reflect clinical reasoning and current evidence
  - Not request visits that exceed the frequency and duration supported in the plan of care
    - Initial plan of care for a musculoskeletal condition should not exceed 4 weeks
- Patient-specific functional goals that are measurable, attainable, time-specific and sustainable
- Specific therapeutic interventions
- Predicted level of improvement in function (prognosis)
- Specific discharge plan

The plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third-party requirements. If a plan of care must be updated or altered, documentation must list all changes/updates, including but not limited to:

- New time frame for current treatment period
- Total number of visits from start of care
- Change in objective outcome measures and standardized testing compared to baseline and/or most recent re-assessment
- Measurable overall progress toward each goal, including whether goal has been met or not met (goals should be updated and modified as appropriate)
- Modification of treatment interventions in order to meet goals
- Collaboration with other services/professionals
- Measurable short- and long-term functional goals that are achievable within the length of time services are requested
- Individualized targeted outcomes that are linked to functional limitations outlined in the most recent evaluation
- Updated intervention and modality selections
  - Evidence-based and chosen to address the targeted goals
- Educational plan to include
  - Home exercises
  - ADL modifications
  - Self-management teaching
- Changed discharge recommendations (including education of the member in a home program)
- Date and signature of treating chiropractor

## **Measurable Progressive Improvement**

### ***Bournemouth – Back Questionnaire*** <sup>(4)</sup>

- Acute: change of 26 points
- Chronic: change of 18 points

**NOTE:** It is recommended that the Bournemouth be used at baseline and for every 2 - 4 weeks or 6 - 12 visits thereafter within the treatment program to measure progress

### ***Bournemouth – Neck Questionnaire*** <sup>(5)</sup>

- A change of 13 points or 36% is considered clinically significant improvement

**NOTE:** It is recommended that the Bournemouth be used at baseline and for every 2 - 4 weeks or 6 - 12 visits thereafter within the treatment program to measure progress

## **Functional Rating Index (FRI) <sup>(6)</sup>**

- Minimal Clinically Important Differences (MCID)
  - Spinal musculoskeletal system = 8.4 points

### **NOTES:**

- Acute and subacute conditions: recommended the FRI be used at baseline and every 1 week or 3 visits thereafter
- Chronic conditions: recommended the FRI be used at baseline and every 2 weeks or 6 visits thereafter
- If the score does not improve by at least 10% (absolute change) in any two successive two-week periods, you should pursue a change in management

## **Neck Disability Index (NDI)**

- MCID
  - Cervical radiculopathy = 7.0 – 8.5 points <sup>(7,8)</sup>
  - Cervical spine fusion = 7.5 points <sup>(8)</sup>
  - Mechanical neck disorders = 5 – 7.5 points <sup>(8)</sup>
  - Mechanical neck disorders = 19% <sup>(8)</sup>
  - Mechanical neck pain = 7.5 points <sup>(7)</sup>
  - Neck Pain (non-specific) = 3.5 points <sup>(8)</sup>
- Minimum Detectable Change (MDC)
  - Cervical radiculopathy = 10.2 – 13.4 points <sup>(8)</sup>
  - Mechanical neck disorders = 10.2 points <sup>(8)</sup>
  - Mechanical neck disorders = 19.6% <sup>(8)</sup>
  - Mechanical pain = 10.2 points <sup>(7)</sup>
  - Neck pain = 5 points (90% CI) <sup>(9)</sup>
  - Neck Pain (non-specific) = 8.4 – 10.5 points <sup>(8)</sup>
- Standard Error of Measurement (SEM)
  - Cervical Radiculopathy = 4.4 – 5.7 points <sup>(8)</sup>
  - Mechanical Neck Disorder = 4.3 – 8.4 points <sup>(8)</sup>
  - Neck Pain (non-specific) = 3.0 points <sup>(8)</sup>

**NOTE:** It is recommended that the Neck Disability Index be used at baseline and for every 2 weeks thereafter within the treatment program to measure progress.

**NOTE:** A score of 0% - 20% represents a minimal disability; usually, no treatment is indicated except for advice on posture, physical fitness, and diet. Patients often do not score the Neck Disability items as zero, once they are in treatment. The practitioner should consider the

patient's prior level of function when goal writing (e.g., the patient's prior level of function would place them in the minimal disability category, their goal should not be to obtain a zero score).

### **Numeric Pain Rating Scale (NPRS)** <sup>(10,11)</sup>

- MCID <sup>(10)</sup>
  - Emergency Room (acute pain) = 1.3 points
  - Low Back Pain (1 week of physical therapy) = 1.5 points
  - Low Back Pain (4 weeks of physical therapy) = 2.2 points
  - Musculoskeletal Pain (Chronic) = 1 point or 15% change
  - Chronic Pain (other; low back pain, osteoarthritis, diabetic neuropathy, post-herpetic neuralgia, fibromyalgia) = 1.7 points or reduction of 27.9%
  - Shoulder Pain = 2.17 points (surgical and nonsurgical subjects after 3-4 week of rehabilitation)
  - Spinal cord injuries (Chronic) = 1.6 – 1.80 points or 36% <sup>(10,11)</sup>
- MDC <sup>(10)</sup>
  - Low Back Pain = 2 points (95% CI)
- SEM <sup>(10)</sup>
  - Low Back Pain = 1.02

### **Oswestry Disability Index (ODI)**

- Minimal Clinically Important Change (MCIC)
  - Lower back = 10 points or a 30% improvement <sup>(12)</sup>
- MCID <sup>(13)</sup>
  - Low back pain (anchor based, ROC) = 7.5% - 16.7%
  - Lumbar Spine Surgery (anchor based (HTI)) = 9.5 – 15.4 points
  - Lumbar Spine Surgery (anchor based (ROC)) = 11.8 – 17.9 points
  - SI Joint Fusion Surgery (anchor based (HTI)) = 19.5% average change
  - SI Joint Fusion Surgery (ROC) = 12.2% - 15.0%
  - Spinal Deformity Surgery = 15.0%
- MDC
  - Back pain = 5.9 – 6.4 points (90% CI) <sup>(13)</sup>
  - Low back pain (subacute and chronic) = 11.1 – 15.35 (95% CI) <sup>(14)</sup>
  - Lumbar fusion = 11.7% - 15.5 % (90-95% CI) <sup>(13)</sup>
- SEM <sup>(13)</sup>

- Back pain (mean duration 6 years) = 4.2 – 4.6 points
- Low/upper back pain (< 1 year) = 2.6% - 2.8%
- Spinal stenosis = 6.1%

**NOTE:** It is recommended that the Oswestry Disability Index be used at baseline and for every 2 weeks thereafter within the treatment program to measure progress.

**NOTE:** A score of 0% -20% represents a minimal disability; usually no treatment is indicated apart from advice on lifting, sitting posture, physical fitness, and diet. Patients often do not score the Oswestry items as zero once they are in treatment. The practitioner should consider the patient's prior level of function when goal writing (e.g., if the patient's prior level of function would place them in the minimal disability category, their goal should not be to obtain a zero score).

## Daily Treatment Note <sup>(3)</sup>

Daily notes should include:

- Standard type format (i.e., subjective, objective, assessment, and plan (SOAP)) and contain the date for return visits or follow-up
- Skilled treatment interventions that cannot be carried out solely by non-skilled personnel. All services and level of services must be supported by the documentation and include the clinical rationale for the treatment intervention, a time component, and goals, if needed.
- Assessment of patient's response or non-response to intervention and plan for subsequent treatment sessions, assessments, or updates
- Changes in clinical status (significant, unusual, or unexpected)

## Re-evaluation

Re-evaluations should not be routine or recurring; an established patient evaluation is indicated if any of the following apply:

- Patient presents with a new condition
- Significant or unanticipated change in symptoms or decline in functional status
- Assessment of response or non-response to treatment at a point in care when meaningful clinical change can reasonably be detected
- Basis for determining the need for change in the treatment plan/goals

The re-evaluation exceeds the parameters of the typical office visit and includes the following:

- Updated history
- Subjective symptoms
- Physical examination findings
- Appropriate standardized outcome tool/measurements as compared to the previous

evaluation/reevaluation

- Evidence to support the need for continued skilled care
- Identify appropriate services to achieve new or existing treatment goals
- Revision in Treatment Plan (i.e., updated goals)
- Correlation to meaningful change in function
- Evidence of the effectiveness of the interventions provided (progress toward goals)

## Utilization Review

Clinical Guidelines have been developed to support medically necessary treatment as part of the peer review process.

Clinical documentation is evaluated when making utilization review determinations. The elements evaluated by a clinical reviewer include, but are not limited to:

- Whether treatment involves an initial trial of care or ongoing care
  - Proposed services/procedures for initial trial or ongoing treatment
  - Reported condition was acute, sub-acute, or chronic at the onset of care
  - Exacerbation or significant flare-up (if applicable)
  - Condition is trauma-related, insidious onset, or repetitive/overuse injuries as a result of activities of daily living
  - Date of onset and mechanism of onset is specified
  - History of the condition
  - Interim history for recurrent episodes
  - Pain (level, intensity, and frequency)
  - Measurable and functional treatment goals are:
    - Appropriate
    - Time-specific
    - Monitored
  - Outcome Assessment Tools
    - Utilized at pre-determined intervals
    - Treatment does not continue after further meaningful change would be minimal or difficult to measure
  - Treatment demonstrates functional improvement that is sustained over time and meets
    - Minimum detectable change (MDC)
- And / Or**
- Minimum clinically important change (MCIC) requirements

- All services billed meet CPT® coding requirements and supported by:
  - Subjective complaints
  - Objective findings
  - Diagnoses
  - Treatment performed
  - Meet the requirements according to this organization’s Clinical Guidelines
- Demonstrated need for skilled services as opposed to home management or unskilled services
- Patients with mild complaints and minimal functional limitations are released to a home exercise program
- Treatment has exceeded 2-3 months for the same or similar condition
- Treatment is provided to patient on an “as needed” basis, without a treatment plan, functional goals, or sustained improvement

## Lack of Information

Reviewers determine that claims/requests have insufficient documentation when the medical documentation submitted is inadequate to support a request for services as medically necessary, such as an initial evaluation, recent progress note and/or the most recent daily treatment notes. Incomplete notes (for example, unsigned, undated, insufficient detail) may also result in a denial for lack of sufficient information.

## Confidentiality of Records

All contracted practitioners will treat patient identifiable health information according to HIPAA standards to ensure the confidentiality of the record and provide the minimum necessary information when requested to perform a review of services.

## CODING AND STANDARDS

### Applicable Lines of Business

☒	CHIP (Children’s Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

## BACKGROUND

### Medical Necessity

Medically necessary services are reasonable or necessary services that require the specific training, skills, and knowledge of a chiropractor in order to diagnose, correct, or significantly improve/optimize as well as prevent deterioration or development of additional physical health conditions. These services require a complexity of care that can only be safely and effectively performed by or under the general supervision of a licensed chiropractor.

- Services shall not be considered reasonable and medically necessary if:
  - They can be omitted without adversely affecting the member's condition or their quality of care
  - Simply because it is furnished by a licensed chiropractor
    - If a service can be self-administered or safely and effectively carried out by an unskilled person, without the direct supervision of a chiropractor, then it cannot be regarded as a skilled service even though a licensed chiropractor actually rendered the service.
    - The unavailability of a competent person to provide a non-skilled service resulting in the non-skilled service being rendered by a chiropractor does not make the service provided a skilled service
  - They include repetitive activities (exercises, skill drills) which do not require a licensed chiropractor's expertise (knowledge, clinical judgment and decision-making abilities) and can be learned and performed by the patient or caregiver
  - They are activities for general fitness, flexibility, sports-specific training enhancement or general tutoring for improvement in academic performance

Medically necessary care must be:

- **Contractual** – all health care services are determined by the practitioner's contract with the payer and individual health plan benefits
- **Within Scope of Practice** – all health care services are limited to the scope of practice under all applicable state and national health care boards
- **Within Standard of Practice** – all health care services must be within the practitioner's generally accepted standard of practice
- **Considerate of Patient Safety** – all health care services must be delivered in the safest possible manner
- **A Medical Service** – all health care services must be medical, not social or convenient, for the purpose of evaluating, diagnosing, and treating an illness, injury, or disease and its related symptoms and functional deficit.
  - These services must be appropriate and effective regarding type, frequency, level, duration, extent, and location of the enrollee's diagnosis or condition
- **Considerate of Setting** – all health care services must be delivered in the least

intensive setting

- **Considerate of Cost** – the practitioner must deliver all health care services in the most cost-effective manner as determined by this organization, the health plan, and/or employer
  - No service should be more costly than an alternative diagnostic method or treatment that is at least as likely to provide the same diagnostic or treatment outcome
- **Supported by Clinical Guidelines**– health care services meet all of the Clinical Guidelines of this organization

## Medical History

The Medical History includes all of the following:

- The History of Present Illness (HPI)
  - includes the location, quality, severity, duration, timing, context, modifying factors that are associated with the signs and symptoms
- A Review of Systems (ROS)
  - 13 systems (musculoskeletal/neurological, etc.) and constitutional symptoms; should also address communication/language ability, affect, cognition, orientation, consciousness
- Past Medical, Family and Social History (PFSH)
  - includes the patient's diet, medications, allergies, hospitalizations, surgeries, illness or injury, the family health status, deaths, problem-related diseases, and
- The patient's social status
  - includes marital status, living conditions, education/occupation, alcohol/drug use, sexual history

## Definitions

**Physical Examination (PE):** Examination of the body areas that includes the head, neck, chest, abdomen, back, and extremities, and the organ systems (11), constitutional, eyes, ENT, CV, GI, GU, musculoskeletal, skin, neurological, psychiatric, lymphatic, immunological, and hematological

**New Patient:** The patient has not been seen at any time by any practitioner within the same group practice, for any purpose, within the last 3 years

## SUMMARY OF EVIDENCE

### Guidelines For Medical Records Documentation <sup>(2)</sup>

The **NCQA Medical Record Documentation** document outlines guidelines for maintaining consistent, current, and complete medical records, which are essential for quality patient care. Here are the key points:

- **Commonly Accepted Standards:** The document lists 21 elements that reflect commonly accepted standards for medical record documentation. These elements include ensuring each page contains the patient's name or ID number, recording personal biographical data, and ensuring all entries are dated and legible.
- **Core Components:** Out of the 21 elements, six are considered core components. These include:
  - Significant illnesses and medical conditions indicated on the problem list
  - Medication allergies and adverse reactions prominently noted
  - Easily identifiable past medical history for patients seen three or more times
  - Working diagnoses consistent with findings
  - Treatment plans consistent with diagnoses
  - No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
- **Additional Recommendations:** Other recommendations include noting the use of cigarettes, alcohol, and substances for patients 12 years and older, ordering laboratory and other studies as appropriate, and ensuring follow-up care is documented.

### Maximizing the Effectiveness and Efficiency of Clinical Documentation <sup>(3)</sup>

Mootz provides a comprehensive overview of the importance and standards for clinical documentation, particularly in chiropractic practice. Key points include:

- **Importance of Documentation:**
  - Clinical documentation is crucial for managed care, integrated practice, clinical accountability, and medicolegal requirements. It should accurately reflect clinical thought processes and patient status.
- **Standards for Record Keeping:**
  - National standards mandate quality records in patient charts. Managed care contracts often stipulate documentation and reporting expectations.
  - Problem-oriented patient management and record-keeping are standard across all healthcare disciplines. This approach includes identifying patient complaints, investigating clinical data, determining clinical impressions, and creating written care plans.
- **Components of Case Management:**

- The case management process includes four components: database (history, examination, special studies), clinical impression (problem list), written plan (diagnostic, treatment, and education plans), and case progress (routine treatment encounters and periodic reevaluation).
- **Efficiency and Consistency:**
  - Consistency and thoroughness in documentation are essential. Abbreviations, preprinted forms, and other shortcuts can be tailored to the clinician's preferences, but charting must be decipherable by external readers.
  - Efficient chart organization separates various components, allowing simplicity of entry and easy review. This includes maintaining a problem list and using SOAP (subjective, objective, assessment, and plan) notes for progress documentation.
- **Recommendations for Improvement:**
  - To improve documentation, clinicians should use standardized abbreviations, preprinted forms, and consistent charting practices. Regular updates to problem lists and treatment plans are recommended.
  - Efficient documentation practices help reduce medicolegal issues, improve communication with third parties, and enhance overall patient care.

## ANALYSIS OF EVIDENCE

### Shared Conclusions <sup>(2,3)</sup>:

- **Importance of Thorough Documentation:** Both articles emphasize the necessity of thorough and accurate documentation in medical records. Mootz 1994 highlights that clinical documentation should reflect clinical thought processes and document the patient's status, which is crucial for medicolegal, insurance, and quality assurance purposes. Similarly, the NCQA Medical Record Documentation underscores that complete and consistent documentation is essential for quality patient care.
- **Standardization of Records:** Both sources agree on the need for standardized record-keeping practices. Mootz 1994 discusses the problem-oriented approach to record-keeping, which includes standardized components like history, examination, and treatment plans. The NCQA document lists 21 commonly accepted standards for medical record documentation, including core elements like patient identification, medication allergies, and past medical history.
- **Legibility and Accessibility:** Both articles stress the importance of legible and accessible records. Mootz 1994 mentions that charting should be decipherable by external readers through abbreviation keys and other means. The NCQA document states that records must be legible to someone other than the writer and that all entries should be dated and contain the author's identification.

## POLICY HISTORY

Date	Summary
December 2025	<ul style="list-style-type: none"> <li>● Added second bullet in General Information section</li> <li>● Added Measures for Measurable Progressive Improvement</li> <li>● Added a Summary of Evidence and Analysis of Evidence</li> <li>● Added and updated references</li> </ul>
November 2024	<ul style="list-style-type: none"> <li>● This guideline replaces Evolent Clinical Guideline 606-02 for Record Keeping and Documentation Standards: Chiropractic Care</li> <li>● Updated references</li> <li>● Removed section on E&amp;M Coding</li> <li>● Removed Scope</li> </ul>

## LEGAL AND COMPLIANCE

### Guideline Approval

#### Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

### Disclaimer

*Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.*

*Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established,*



*we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.*

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# Evolut Clinical Guideline 1511 for Active Procedures, Passive Treatment, and Experimental, Unproven, or Investigational Services

<b>Guideline Number:</b> Evolut_CG_1511		
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## STATEMENT

### General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

### Purpose

The purpose of the guideline includes the following:

- Assist the physical medicine provider to accurately choose the appropriate service(s) when indicated for case management
  - Introduction and management of active care procedures should begin as soon as clinically possible
  - Evidence shows active care services support outcomes when used alone or in combination with manual-based treatments and/or passive care services <sup>(1,2)</sup>
  - This organization does not support the use of multiple passive treatments for the care of musculoskeletal pain
  - Most passive treatments have similar physiological effects related to pain control and reduction of inflammation
    - The use of treatments with duplicative physiological effects is unnecessary and inappropriate
- To provide a listing of procedures or services considered experimental, investigational, or unproven provided by any physical medicine practitioner (see **Background**)

### Special Note

Parts of this policy list procedures considered experimental, or investigational provided by any physical medicine practitioner (see **Background**)

**NOTE:** Services listed as experimental or investigational are not eligible for reimbursement.

### Scope

This guideline applies to all physical medicine participating network practitioners, including rendering chiropractors, physical therapists, occupational therapists, speech therapists, and

therapist assistants as applicable. This guideline also applies to out-of-net network practitioners as dictated by the health plan.

## Clinical Reasoning

Interventions chosen to treat the patient's (member's) symptoms/conditions should be based on the most effective and efficient means of achieving the patient's functional goals. <sup>(3)</sup>

## Coverage

If there is inconsistency between this medical policy and the terms of a member's benefit plan, the terms of the member's benefit plan supersede this policy.

**NOTE:** Coverage is subject to the terms of a member's benefit plan

## MEDICAL NECESSITY

Written documentation should include evidence to support medical necessity including the following <sup>(4)</sup>:

- Services are skilled, safe, and effective
- Skilled services are required **AND** provided by skilled clinicians (see **Background**) (or qualified professionals when appropriate with approval of a physician/NPP)
- Skilled clinicians must apply their skills and actively participate in the treatment of the member during each progress report period and document skilled treatment provided or modification to skilled treatment
- Skilled clinicians must have the expertise, knowledge, clinical judgment, and decision-making abilities that otherwise caretakers and members do not have independently

## DOCUMENTATION REQUIREMENTS

- Evaluation and Plan of Care by a skilled and appropriately licensed clinician must include <sup>(4)</sup>:
  - Initial and re-evaluations which provides:
    - Evidence to support medical necessity for the course of therapy through objective findings and subjective member self-reporting
    - Evidence to support member-specific need for care and intervention to address limitations in activities of daily living (ADL), instrumental activities of daily living, health management, rest and sleep, social participation, mobility, and safety <sup>(5)</sup>
    - A timeline for initiating, progressing, and discharging members from skilled services
    - Specific treatment parameters to support the intervention (appropriate service

type, frequency, intensity, and duration for individual need of the member)

- Measurable goals related to functional limitations that support the identified skilled intervention with identified precautions
- Progress Reports or Daily Treatment Notes which provides <sup>(4)</sup>:
  - Justification for the medical necessity of treatment or treatment change
  - Functional improvement as a result of improved objective and/or outcome assessment measures
  - Clear evidence of recent and significant progress with treatment which could be indicated by progress towards functional goals
  - Clear evidence to support the continued need of a skilled medical provider
  - If there is a lack of progress, justification for continued treatment
  - Any barriers to establishing an independent home program,
  - non-compliance with the established program, and clear evidence that the home program is evolving and continues to require skilled adjustments
- Documentation includes:
  - Specific skilled services that are being provided
  - Medical necessity of the interventions performed
  - Supportive evidence for the number of visits (including excess to the standards for treatment of musculoskeletal conditions)
  - Functional improvement (as a result of skilled interventions)
  - Evidence that skilled services of a physical medicine provider/practitioner (see **Background**) are needed (beyond establishment of the home program)
  - Evidence that interventions are part of a comprehensive rehab program with the goal of improving the functional status
    - Interventions should be unique and not repetitive when compared to other recent treatment sessions
  - Treatment plan or plan of care must include:
    - Evidence that the plan of care is guided by functional impairments, not the intervention itself
    - Treatment of the patient during each progress report period and document skilled treatment provided or modification to skilled treatment
    - Clinical rationale and goal for each service
    - Description of the service
    - Time component if indicated

## APPROPRIATE USE OF SERVICES

### Clinically Appropriate Use of Passive Treatment:

- Used primarily during the initial period of an episode of treatment or exacerbation of a sub-acute or chronic condition for pain control, reduction of inflammation, or reduction of muscle spasm. <sup>(6-9)</sup>
- Used to facilitate progression into more active interventions or when active care is not tolerated
- When there are no contraindications to the intervention
- Self or caregiver administration is implausible or places the member at risk of harm.
- Used to support an active care approach (i.e., therapeutic exercise)
- Passive interventions should only be reservedly used based upon individual circumstances and not as a principal component of a treatment regime. <sup>(9,10)</sup> Used for a particular condition for which there is an evidence-basis of significant long-term benefit.

### Clinically Inappropriate Use of Passive Treatment

- When member safety is jeopardized by the application of the modality
- When the treatment can safely and effectively be administered by the member or another individual
- Used during a course of treatment, which continues beyond the initial period.
  - As a condition progresses passive care should be replaced by active treatment modalities, such as therapeutic exercise. Insufficient evidence exists to support the continued use of passive treatment as a means for improved clinical outcomes
- Used as the primary or sole therapy
- More than two passive treatments are used involving the same body region(s)
- Used largely for the comfort and convenience of the member
- Used as part of the routine office protocol
- Continued use when effectiveness has not been demonstrated within initial 3-4 treatments

### Exclusions

- The use of chiropractic manipulation (CPT codes: 98940 - 98943) is not considered a duplication of service or physiological effect when used in conjunction with passive treatment, except for the following:
  - The National Correct Coding Initiative (NCCI) edits require that the manual therapy techniques be performed in a separate anatomic site than the chiropractic adjustments in order to be reimbursed separately

## INDICATIONS FOR ACTIVE PROCEDURES

### 97110 - Therapeutic Exercise

#### ***Defined***

- Therapeutic exercise is any exercise planned and performed to attain a specific goal (increase strength, endurance, range of motion, and flexibility)
- Therapeutic procedures/exercise could be applied to one or more areas

#### ***Parameters***

The following must be documented in the medical record to support/justify the use of all therapeutic procedures and exercises:

- Detailed active care services including:
  - Which exercise(s) were provided
  - What body area (including muscle groups) the exercise(s) target
  - Service/exercise:
    - Amount and type of resistance
    - Number of repetitions and sets
    - Time component
- Evidence to support the need for the patient's skilled services completed by a licensed professional (see **Background**)

The initiation of appropriate therapeutic procedures/exercise begins as soon as the member is reasonably able to engage in the planned activity. The expectation is for the member to learn and perform therapeutic exercises with a detailed home program within a reasonable timeframe. <sup>(11,12)</sup>

The use of high-tech fitness equipment (e.g., MedX equipment, cervical/lumbar extension machines, Isostation B-220 Lumbar Dynamometer, Cybex Back System, exoskeleton systems) lacks evidence of improved outcomes compared to the use of standard exercise equipment. <sup>(13)</sup>

#### ***Services Support***

The following are indications of the skilled services required to support the use of therapeutic exercise (supportive evidence documented). Without documented evidence, the records would suggest the member is 'working out' in the clinical setting (considered not medically necessary and not eligible for reimbursement).

- Loss or restriction of joint motion, reduced strength, and functional capacity or mobility concerns
  - The clinical records need to objectively validate (quantitative if possible) the loss of range of motion, strength, flexibility, or functional mobility

- If quantitative measures are not provided, the reason for the lack of assessment must be documented
- The therapeutic exercise code is generally NOT reimbursable for:
  - Increasing a member's endurance without deficits
  - Promotion of overall fitness
  - Weight loss
  - Return to work
  - Return to sports (sports/recreation and/or sports/aerobic conditioning)
- Services are required and provided by skilled clinicians (see **Background**)(or qualified professionals when appropriate with approval of a physician/NPP)
- Member competency and compliance with instructions require:
  - One to three billing units at a time
  - More than 3 billing units needs supported clinical documentation
- Member should perform exercises in the clinic for the purposes of:
  - Ensuring competency with a home program
  - Progressing exercises as care advances
  - **NOTE:** Exercise in the clinic is not supported when exercises are repetitive over multiple visits without a documented reason
    - Active care program may include periodic review as part of case management in regard to monitoring continued therapeutic benefit and progression
    - Case management should outline:
      - Member compliance
      - Alterations and progression to active home program
      - Anticipated termination date for skilled in-office services

### ***Noncompliance***

- Member non-compliance with active home instructions
  - In-office instruction will no longer be medically necessary
  - Member will be discharged for non-compliance, acting against medical advice

### ***Services not covered:***

#### **Return to work:**

- Treatment addressing functions that are specific to the performance of job duties (i.e. advanced lifting outside of daily functions, work hardening, work conditioning, repetitive work tasks)

- Evaluation of work specific abilities or assessments with the intent to measure disability ratings (i.e. functional capacity evaluations)
- Education that is specific to a work task (i.e. beyond the scope of teaching basic posture, body mechanics, and injury prevention)
- Documentation must support why education for body mechanics, proper lifting, etc. could not be completed within limited visits

### **Return to Sport or Recreation**

- Treatment with a focus on advancing the skills and abilities needed to perform a sport or recreational activity that are not needed for typical daily function.
- Treatment addressing higher level functions (i.e. running, jumping, cutting, throwing) requires documentation to support that these skills are needed as part of daily function, or that care is needed to educate on proper mechanics for these functions to reduce risk of re-injury
- In phases of treatment where education is needed for advanced skills, frequency of care is typically expected to be low, allowing for practice on these skills within a concurrent home program

### **Ultraviolet Treatment for Psoriasis**

- Treatment of psoriasis with UV does not alone require the skills of a therapist to administer. Documentation for this service must show that the intervention is needed to address a functional impairment (i.e. severe loss of range of motion) and be provided in conjunction with active interventions

### **Pre-Operative Care That Is Not Specific to Individual Patient Deficits**

- Treatment in groups or individual therapy must show the skills of a therapist outside of providing post-operative exercises and education before surgery. Care must address deficits expected to impair post-operative outcomes in the absence of pre-operative care. Treatment must not be part of a standard protocol for all patients receiving the same surgery.

## **97112 - Neuromuscular Re-Education** (14,15)

### ***Defined***

- Neuromuscular re-education is a series of therapeutic techniques of movement, balance, coordination, kinesthetic sense, posture, and proprioception to restore normal function of nerves and muscles
  - Neuromuscular deficits requiring re-education may be associated with stroke, closed head injury, spinal cord injury, tumor, congenital disorders (cerebral palsy, genetic conditions, or secondary to degenerative joint disease), musculoskeletal injury (ankle sprain, post orthopedic surgery, or prolonged immobilization) <sup>(16)</sup>
- Neuromuscular re-education may be considered medically necessary if at least ONE of the following conditions is present (documented)

- The loss of deep tendon reflexes and vibration sense accompanied by
  - Paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers
- Nerve palsy (e.g., peroneal nerve injury causing foot drop)
- Muscular weakness or flaccidity from
  - Cerebral dysfunction
  - Nerve injury or disease
  - Spinal cord disease
  - Trauma
- Muscle compensations requiring targeted exercise to produce stable, coordinated movements during functional tasks <sup>(17)</sup>
- Peripheral or central vestibular dysfunction causing dizziness, vertigo, imbalance, or disequilibrium that supports the use of Vestibular Balance and Rehabilitation Therapy (VBRT) <sup>(18,19)</sup>

## **Services Support**

The following are indications of the skilled services required to support the use of neuromuscular re-education (supportive evidence documented):

- Document the need for individual, in direct contact skilled therapy services by a licensed professional (see **Background**)
- Document the injury to the neuromuscular skeletal system and the therapeutic procedure(s)
- Provide and document home care instructions and education

## **97113 - Aquatic Therapy**

### **Defined**

- Aquatic therapy is the skilled practice by a qualified clinician directed towards an individual and involves the use of therapeutic exercise techniques with the properties of water to improve function
- Aquatic therapy treatment aims to improve circulation, decrease venous pooling, increase endurance with less stress on weight-bearing joints, and enhancement of balance and coordination as a result of the buoyancy obtained from an aquatic environment.
- Aquatic therapies include:
  - Clinical Ai Chi <sup>(20)</sup>
  - Aquatic PNF <sup>(21)</sup>
  - Bad Ragaz Ring Method (BRRM) <sup>(22)</sup>

- Halliwick-Therapy <sup>(23)</sup>
- Watsu (WaterShiatsu) <sup>(24)</sup>
- Aquatic Cardiovascular Training (ACT) <sup>(25)</sup>

## **Services Support**

The following are indications of the skilled services required to support the use of aquatic therapy (supportive evidence documented):

- Document the need for individual, direct-contact skilled therapy services by a licensed professional (see **Background**)
- Provided in a pool of water deemed safe and appropriate for patient therapy
- Provide the member's medical necessity for aquatic therapy (e.g., buoyancy, hydrostatic pressure, and heat) to transition to standard land-based therapy and the anticipated reasonable timeframe to make that transition

## **97116 - Gait Training**

### **Defined**

- Training the member to ambulate on varied surfaces and stair climbing with or without an assistive device; this includes training in rhythm, speed, sequencing, and safety

### **Services Support**

The following are indications of the skilled services required to support the use of gait training (supportive evidence documented):

- Consider the contextual factors that affect the member's ability to participate in meaningful ADLs <sup>(5)</sup>
- Gait training and ambulation interventions should directly address functional mobility
- Document the need for individual skilled therapy services by a licensed professional
- Document deficits in gait parameters including:
  - Walking speed
  - Cadence
  - Stride length and balance
  - Functional ambulation category scores
- Document if body-weight support (BWS) systems, unweighting devices, or assistive devices are used
- Documentation should include the assessment of the phases of gait to include:
  - Stance phase
  - Stride length

- Balance issues
- Ankle, knee, hip, and low back impact during the phases of gait cycle

## **97760 - Orthotics Management and Training**

### ***Defined***

- Assessment and fitting when not reported as a separate L HCPCS code (L-code)
- Fitting and training
- Upper or Lower extremity (extremities) and/or trunk, each 15 minutes

### ***Additional Information***

- Applies to custom-fabricated or adjustments to over-the-counter orthotics
- Orthotics management refers to time spent assessing the need, type, fitting and fabrication of the orthotic (if fabrication is done in the presence of the patient)
- Code cannot be used if the orthotic is fabricated or formed without the patient being present
- Training in the care and use of the orthotic device
- Supplies and time for orthotic fabrication is typically reported under L-codes (If an L-code is NOT used to report the orthotic then the time assessing and fitting/fabricating would be reported under code 97760)

### ***Services Support***

The following are indications of the skilled services required to support the use of orthotic management and training (supportive evidence documented):

- Document the need for individual skilled therapy services by a licensed professional (see **Background**)
- Orthotics require documented support
  - Proper examination (not vendor specific evaluation)
  - Outline the causal nexus to justify inclusion (all complaints other than foot-based)
    - Foot-based complaints need further notation as to the fault/deficit present requiring custom orthotics versus heel lift or over-the-counter orthotics.
  - Member should typically not be seen more than once per calendar year for one set of orthotics
  - Orthotic use is based on plan benefit

## 97761 - Prosthetic Training

### ***Defined***

- Assessment of the functional mobility and ADLs (Activities of Daily Living) while training and practicing with the prosthesis
- Training with the prosthesis (upper and/or lower extremity)
  - Instruction and practice in use of prosthesis

### ***Services Support***

The following are indications of the skilled services required to support the use of prosthetic training (supportive evidence documented)

- New prosthetic device or adjustments to current prosthetic device to improve function

## 97763 - Checkout For Orthotic/Prosthetic Use - Established Patient

### ***Defined***

- Training and management of subsequent encounters for orthotic(s) or prosthetic(s) for the upper/lower extremity(ies) and/or trunk

### ***Services Support***

- Document the need for individual skilled therapy services by a licensed professional (see **Background**)

## 97530 - Therapeutic Activities

### ***Defined***

- Dynamic activities in teaching/training the member to improve functional performance in a progressive manner

### ***Services Support***

The following are indications of the skilled services required to support the use of therapeutic activities (supportive evidence documented):

- Document the need for individual skilled therapy services by a licensed professional (see **Background**)
- Coverage for therapeutic activities - ALL of the following requirements must be met:
  - The patient has a condition for which therapeutic activities can reasonably be expected to restore or improve function
  - The member is unable to perform therapeutic activities (due to condition) except

- under the direct supervision of a skilled and licensed therapy services professional
- Correlation between the patient's underlying medical condition and the type of exercise performed for which the therapeutic activities were prescribed
  - The therapeutic exercise code is generally NOT reimbursable for:
    - Increasing a member's endurance without deficits
    - Promotion of overall fitness
    - Weight loss
    - Return to work
    - Return to sports (sports/recreation and/or sports/aerobic conditioning)

## **97129 - Cognitive Skills Development**

### ***Defined***

- Therapeutic interventions focusing on cognitive function for:
  - Attention
  - Memory
  - Reasoning
  - Executive function
  - Problem solving
  - Pragmatic functioning
- Compensatory strategies to manage performance related to functional ADLs
  - Managing time or schedules
  - Initiating, organizing, and sequencing tasks

### ***Services Support***

The following are indications of the skilled services required to support the use of cognitive skills development (supportive evidence documented):

- Document the need for individual skilled therapy services by a licensed professional (see **Background**)
- Document cognitive deficits (quantifiable)

## **97533 - Sensory Integration**

### ***Defined***

- Treatment techniques to enhance sensory processing and adaptive responses to environmental demands

- Improve how the brain processes sensory information, organizes and responds appropriately for complex learning behavior

### ***Additional Information***

- Sensory integration (SI) therapy - treatment of developmental, environmental, or acquired brain disorders in patients with established dysfunction of sensory processing which may be associated with:
  - Neurodevelopmental Disorders such as Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Intellectual Disability, Conduct Disorders, and Language Communication Disorders that may be caused from:
    - Fetal alcohol syndrome
    - Genetics
    - Neurotransmitter imbalance
    - Illness
    - Brain injury
- Therapy activities may provide one or more of the following stimuli with the intent to help organize the sensory system and promote adaptive responses to environmental demands:
  - Vestibular
  - Proprioceptive
  - Tactile
  - Visual
  - Auditory

**NOTE:** Sensory Integration differs from neuromuscular re-education (97112). Neuromuscular re-education focuses on training to restore the ability to perform particular activities versus training to enhance sensory processing and adaptive responses.

### ***Services Support***

The following are indications of the skilled services required to support the use of sensory integration treatment (supportive evidence documented):

- Document the need for individual skilled therapy services by a licensed professional (see **Background**)
- Document sensory processing deficits impacting functional skills
- Sensory integration therapy provided by occupational and physical therapists

## 97535 - Self-Care/Home Management Training

### **Defined**

- Instructing and training the patient in self-care and home management activities (ADL/IADLs)
  - Compensatory training
  - Safety procedures
  - Instruction in the use of assistive technology devices and adaptive equipment

### **Services Support**

The following are indications of the skilled services required to support the use of self-care/home management training (supportive evidence documented):

- Document the need for individual skilled therapy services by a licensed professional (see **Background**)
- Document the related ADL instruction to the patient's expected functional goals and indicate it is part of an active treatment plan directed at a specific goal

## 97542 - Wheelchair Management and Training

### **Defined**

- Assessment, fitting, and adjustment of the wheelchair and seating
- Instructing the member and/or caregiver on how to propel and safely operate the wheelchair

**NOTE:** 97001 and 97002 cannot be billed with this code

### **Services Support**

The following are indications of the skilled services required to support the use of wheelchair management and training (supportive evidence documented):

- Document the need for individual skilled therapy services by a licensed professional (see **Background**)
- Document the current event that prompted a skilled wheelchair assessment
- Document results of prior wheelchair assessments
- Document functional level (current and previous)
- Document interventions attempted by nursing staff, caregivers, and/or the member to address poor seating or positioning
- Documentation correlates the training provided to expected functional goals by the member and/or caregiver

- Document the response of the member to the instruction or fitting

## **97537 - Community Work Reintegration**

**NOTE:** 97537 Community work reintegration is typically not a covered service.

### ***Defined***

- Instructing and training the member in community and/or work re-integration activities <sup>(26,27)</sup>:
  - Shopping
  - Safely accessing transportation sources
  - Money management
  - Avocational activities or work environment modification analysis
  - Work task analysis
  - Assistive technology devices and/or use of adaptive equipment

### ***Additional Information***

- Community reintegration is performed in conjunction with other therapeutic procedures such as:
  - Gait training
  - Self-care or home management training
- Billing is often bundled into the payment for other services; other services are not usually reimbursed separately
- The following services on assistive technology devices and/or adaptive equipment provided to the member by a third-party payer are not covered if the devices/equipment are not covered by the third-party payer:
  - Issue
  - Modify
  - Adjust
  - Educate
- Services related to the listed items are not considered reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage according to Section 1862(a)(1)(A) of the Social Security Act <sup>(28)</sup>:
  - Employment opportunities
  - Work skills
  - Work

## ***Services Support***

The following are indications of the skilled services required to support the use of community work reintegration (supportive evidence documented):

- Document the need for individual skilled therapy services by a licensed professional†

## **97545 - Work Hardening/Conditioning**

### ***Additional Information***

- Work-induced injury and/or impairment that resulted in the need for therapeutic exercises/procedures
- Completed acute medical care (chiropractic or rehabilitation treatment) by the patient may require a comprehensive and individualized program for safely returning to work
- Member may begin a work hardening and/or work conditioning program
  - Member will participate in a program for at least two hours a day, three days a week up to eight hours a day, five days a week
  - Activities in the program may include:
    - Exercise regimen
    - Simulation of specific or general work requirements
    - Training and/or modifications of activities of daily living
    - Injury prevention training
    - Cognitive-behavioral pain management
    - Occupational/educational training

## ***Services Support***

The following are indications of the skilled services required to support the use of work hardening/conditioning (supportive evidence documented):

- Documentation the member had an injury and/or impairment within the last 12 months
- Documentation the member has received acute rehabilitation services and is expected to return to his/her previous employment
- Document the member's limitations regarding:
  - Returning to work
  - Willingness to participate in the program
- Document plan of care (structured and goal-oriented), including discharge from skilled services and a reference to return to work
- Identify systemic neuromusculoskeletal deficits that interfere with work
- Document care is at the point of resolution for the initial or principal injury so that

participation in the conditioning process is not prohibited

- Identify psychosocial and/or vocation problems and evidence of a referral to the appropriate professional

## INDICATIONS FOR PASSIVE PROCEDURES

### Thermotherapy/Cryotherapy

The superficial or deep application of heat or cold.

- Superficial
  - Hot/cold packs
  - Paraffin bath
  - Whirlpool
- Deep
  - Diathermy
  - Microwave
  - Ultrasound (US)

**NOTE:** Thermal therapy has been found to be most successful in the short-term relief of musculoskeletal pain but is also often used in conjunction with other therapies to improve outcomes. <sup>(29,30)</sup>

**NOTE:** Ultrasound therapy is used as both thermal therapy and mechanical therapy <sup>(31)</sup> and may provide short-term pain relief for knee osteoarthritis. <sup>(32,33)</sup>

### Light Therapy (aka Phototherapy)

Light concentrated in a narrow beam to excite cells in local tissues.

- Ultraviolet
- Infrared
- Laser therapy
  - Low level
  - High level

**NOTE:** Ultraviolet therapy is primarily used to treat skin disorders and promote wound healing.

**NOTE:** Both low (including infrared) and high-level laser therapy have been shown effective in reducing pain and as adjuncts to other physical therapy modalities. <sup>(32,34,35)</sup>

## Electrical Stimulation Therapy

- Administration of an electrical current to a specific, localized body site.
- Volt
  - High
  - Low
- Interferential current (IFC)
- Transcutaneous electrical nerve stimulation (TENS)
- Neuromuscular electrical stimulation (NMES)

**NOTE:** IFC and TENS have consistently been found to reduce pain during and shortly after application, helping facilitate other therapies and/or improving outcomes. <sup>(36,37)</sup>

## Mechanical Therapy

Mechanically assisted and often sustained pull of the spine or limb

- Traction

**NOTE:** Lumbar traction has been shown to be effective in relieving low back pain and lumbar radiculopathy. <sup>(38,39)</sup>

**NOTE:** Cervical traction may offer some short-term pain relief for neck pain and cervical radiculopathy. <sup>(40,41)</sup>

## Therapeutic Massage and Manual Therapy

Includes but not limited to:

- Active Release Technique
- Trigger point therapy
- Myofascial release
- Mobilization/manipulation
- Manual lymphatic drainage
- Manual traction

**NOTE:** A range of manual therapies have been found to be effective in treating tension-type headaches. <sup>(42,43)</sup>

**NOTE:** Manual therapies can decrease pain, increase range of motion, and improve functionality in a range of musculoskeletal conditions, including osteoarthritis. <sup>(32,44,45)</sup>

# INDICATIONS FOR EXPERIMENTAL, UNPROVEN, OR INVESTIGATIONAL SERVICES

## Defined

Experimental and investigational services (treatment, service, procedure, supply, device, or drug) are not recognized as standard clinical care for the condition (disease, illness, or injury) when scientific evidence to support its use is insufficient.

A service, procedure, or supply includes but is not limited to:

- Diagnostic service
- Treatment
- Facility
- Equipment or device

**NOTE:** This organization will determine whether a service, procedure, or supply is considered experimental and investigational, based upon reliable scientific methodology published in credible peer-reviewed journals or expert opinion from national and international professional medical organizations in the absence of definitive data.

## Criteria

A service is considered experimental/investigation if **ANY** of the following criteria is met:

- A service, treatment, procedure, supply, device, or drug requiring appropriate government regulatory bodies approval does **NOT** have final approval (e.g., the Food and Drug Administration)
  - Restricted market approval for use in the treatment of a specified condition (not substituted for final approval)
  - Interim step in the regulatory process (not substituted for final approval)
- Insufficient or inconclusive evidence of the service, procedure, or supply
  - To evaluate the therapeutic value
  - On the beneficial effect on health outcomes
  - Is not as beneficial as an established alternative
  - When used in a non-investigational setting the service, procedure, or supply has a beneficial effect on health outcomes as any established alternatives

## Services

Experimental and investigational services listing (**non-exclusive list**):

- Advanced BioStructural Correction™ (ABC™)
- Alfabiotics

- Applied Kinesiology (including subfields)
- Applied Spinal Biomechanical Engineering
- Bio-Energetic Synchronization Technique (B.E.S.T)
- Blood Flow Restriction Training
- Chiropractic Biophysics (CBP, Clinical Biomechanics of Posture, CBP Mirror Image Technique)
- Chiropractic services directed at controlling progression and/or reducing scoliosis, including but not limited to the SpineCor brace and CLEAR scoliosis treatment
- Coccygeal Meningeal Stress Fixation
- Cold Laser Therapy
- Computerized muscle testing or analysis
- Cupping
- Craniosacral Therapy (CST, including the Upledger Technique)
- Directional Non-force Technique
- Hako-Med electrotherapy (horizontal electrotherapy)
- High-density surface electromyography (HD-sEMG), surface scanning EMG, paraspinal surface EMG, or macro EMG (e.g., evaluating low back pain, thoracolumbar segmental abnormalities, soft tissue injury, intervertebral disc disease, nerve root irritation, or scoliosis)
- Hippotherapy
- Impulse adjusting instrument
- Intersegmental traction and Autotraction
- Live Cell Analysis or hair analysis
- Moire Contourographic Analysis
- Nambudripad's Allergy Elimination Technique (NAET)/ other Allergy Testing
- National Upper Cervical Chiropractic Association (NUCCA technique)/Grostic technique
- Network Chiropractic, Neuro Emotional Technique (NET)
- Neural Organizational Technique, Contact Reflex Analysis (CRA), Whole System Scan
- Neurocalometer, Nervo-Scope, Nerve Conduction Velocity, Surface EMG, Paraspinal Electromyography, Spinoscopy or other nerve conduction testing for non-specific neck and back pain
- Neurophysiologic Pain Profile (NPP), spine matrix scan (lumbar matrix scan)
- Nimmo Receptor-Tonus method

- Pettibon, including, but not limited to wobble chair/board treatment and posture pump
- Preventive Care, Corrective Care (chiropractic services)
- Pro-Adjuster
- Sacro Occipital Technique, Neurocranial Restructuring (NCR), Cranial Manipulation
- Sound Assisted Soft Tissue mobilization
- Spinal Diagnostic Ultrasound
- Repeat imaging to determine the progress of conservative treatment
- Thermography
- Treatment for brachioradial pruritis
- Vascular Studies, including, but not limited to, Doppler ultrasound analysis and **plethysmography**
- VAX-D, Lordex, LTX3000, DRX-9000, DRS (Decompression Reduction Stabilization System), or other back traction devices charged at a higher rate than mechanical traction (97012)
- Any lab work for which the office is not CLIA Certified or falls outside of the scope of practice, including, but not limited to drug testing, therapeutic drug assays, and organ or disease-oriented panels

## Services Exceptions (Possibly Covered Under Another Service)

- Low level laser therapy could be an effective method for relieving pain in non-specific chronic low back pain <sup>(46)</sup>

**NOTE:** No significant treatment effect was identified for disability scores or spinal range of motion outcomes. Laser therapy combined with exercise provides better short-term relief of low back pain than either therapy alone. <sup>(47)</sup> No short-term benefit of laser therapy when compared with exercise alone. <sup>(47)</sup>

## ***Plethysmography***

- **Plethysmography** is one diagnostic modality for the conditions listed below or as an initial evaluation to determine the need for venography or arteriography
  - Chronic venous disease <sup>(48,49)</sup>
  - Arterial occlusive disease <sup>(50)</sup>
  - Evaluating total lung capacity and residual volume (Body Plethysmography/Pulmonary Function Test) <sup>(51)</sup>

**NOTE:** Since treatment of cardiovascular and lung conditions falls outside of the scope of chiropractic, patients should be referred for testing if these conditions are suspected.

## Election of Services by Member

- If an experimental, unproven, or investigational service are to be provided, the practitioner will inform the member, in writing, that such services will be the member's responsibility
  - No services are to be performed in lieu of an appropriate examination or without consideration of an appropriate referral
- There is limited scientific evidence that the use of experimental, investigational, and unproven services provides a more accurate diagnosis, nor do they result in an improved clinical outcome
- For member exclusions or limitations refer to the enrollee's Certificate of Coverage or Summary Plan Description

## Future Considerations

### Removal of a service from the Experimental and Investigations Policy

- A review of the current literature will be evaluated annually to determine if there is additional evidence in support of any of the services listed under this policy (governmental regulatory bodies approval and scientific evidence)
- Scientific evidence must demonstrate the final conclusions pertaining to a treatment are based upon sound scientific study methodology published in credible, peer reviewed journals following a hierarchy of reliable evidence is used:
  - Systematic reviews or Meta analyses of randomized controlled trials
  - Technology assessments
  - Randomized Controlled Trials
  - Cohort studies
  - Case-Control studies
  - National and International Professional Medical Societies consensus (in absence of definitive scientific data)

**NOTE:** reliable evidence comes from well designed, high quality, double-blinded studies and not from personal professional opinions or personal choice for the standard of practice

- Services must be proven safe and effective:
  - Safety
    - potential benefit must be substantially superior to the potential harm
  - Health Outcomes
    - Superior or comparable to the established alternatives
  - Patient Management
    - Does the service improve clinical decision making

- Clinical Performance
  - Is the reliability and predictive value of the service equal or superior to the current gold standard for the service
- Cost-effectiveness
  - Is the service equal to or lower cost than established treatments that produce similar outcomes

**NOTE:** If the service appears to be safe and cost-effective, this organization will present these results to our health plan partners for consideration of coverage and/or payment. Final authority for such coverage determinations rests with the health plan.

## CODING AND STANDARDS

### Applicable Lines of Business

☒	CHIP (Children’s Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

## BACKGROUND

### Health Care Providers

A qualified licensed health care providers (chiropractors, physical therapists, occupational therapists, speech language pathologist, physician assistants, speech language pathologist assistants, physical therapist assistants, and occupational therapy assistants) by education, training, and licensure/regulation performs a professional service within his/her scope of practice and reports to health professional boards.

### Definitions

**Modality:** any group of agents that may include thermal, acoustic, radiant, mechanical, or electrical energy to produce physiologic changes in tissues for therapeutic purposes. Modalities affect tissue at the cellular level.

**Multiple Modalities:** the use of and/or billing of two or more physical medicine modalities each visit or during the same session to the same region.

**Passive Treatment:** treatment that is applied by the provider or in a clinical setting and does not involve active participation by the member.

**Procedure:** a service provided to increase the functional abilities in self-care, mobility, or safety.

## SUMMARY OF EVIDENCE

### Epidemiology, Diagnosis, and Treatment of Neck Pain <sup>(1)</sup>

Cohen provides a comprehensive overview of the evidence and recommendations for various therapy services for neck pain, such as:

#### Active Therapies

- **Exercise Therapy:** This is beneficial for mechanical neck pain and involves cervical and scapular stretching and strengthening exercises. It provides intermediate-term relief and is recommended for both acute and chronic neck pain.
- **Physical Therapy:** In a randomized study, physical therapy combined with home exercises showed greater reductions in neck pain and disability over a 6-week period compared to a "wait and see" approach.

#### Passive Therapies

- **Spinal Manipulation:** This manual therapy aims to maximize painless movement, reduce muscle tightness, and improve joint mobility. It is superior to no treatment or sham treatment in the short term.
- **Massage Therapy:** This involves the manipulation of muscle and connective tissue to enhance function and promote relaxation. It is superior to no treatment or sham treatment but not more effective than other active treatments in the short and intermediate term.
- **Acupuncture:** Inserting needles into the skin at various anatomic locations to reduce pain. There is weak evidence that acupuncture is superior to no treatment in the short term.

#### Experimental Therapies

- **Epidural Corticosteroid Injections:** These are used for cervical radiculopathy. The results of clinical trials are mixed, with some studies showing significant benefits and others showing no differences compared to placebo.
- **Radiofrequency Ablation:** This is used for cervical facet joint pain. The evidence is weakly positive, with some studies showing benefits for pain relief and functional improvement.

### Exercise interventions for the treatment of chronic low back pain: a systematic review and meta-analysis of randomised controlled trials <sup>(2)</sup>

Searle et al. provides a comprehensive review of exercise interventions for the treatment of chronic low back pain, including:

### Active Therapy Services

Active therapy services involve exercises that require patient participation and effort. The document highlights the following:

- **Strength/Resistance Exercises:** These exercises showed a small but significant effect in reducing chronic low back pain. They focus on improving strength, power, and functional abilities by targeting multiple muscle groups.
- **Coordination/Stabilization Exercises:** These exercises also demonstrated a small but significant effect. They typically focus on strengthening core muscles like the lumbar multifidus and transversus abdominus, which are essential for core stability.

### Passive Therapy Services

Passive therapy services involve treatments that are done to the patient without their active involvement. The document mentions:

- **Electrotherapies:** Treatments like ultrasound and laser therapy were compared with exercise interventions. However, the document does not provide strong evidence supporting their effectiveness over active exercise interventions.
- **Manipulative Therapies:** These include physiotherapy, massage, and osteopathy. Similar to electrotherapies, the evidence suggests that active exercise interventions are more effective in reducing chronic low back pain.

### Experimental Therapy Services

Experimental therapy services are those that are still being studied and are not yet widely accepted as standard treatments. The document discusses:

- **Cardiorespiratory Exercises:** These exercises did not show a significant effect in reducing chronic low back pain. The trials included in the review may not have met the duration or intensity requirements necessary to observe a therapeutic effect.
- **Combined Exercise Programs:** These programs include a mix of strength, endurance, stretching, and aerobic components. While they generally showed a positive effect, the results were not consistently significant.

### Occupational Therapy Practice Framework: Domain and Process—Fourth Edition <sup>(5)</sup>

The OT Practice Framework - 4th Edition provides a comprehensive overview of occupational therapy practice, including:

#### Active Therapy Services

Active therapy services involve exercises that require patient participation and effort. The document highlights the following:

- **Occupations and Activities:** These are personalized and meaningful daily life events that are designed to meet therapeutic goals. Examples include completing morning dressing and hygiene using adaptive devices, playing group games to improve social participation, and creating apps to improve access for people with disabilities.

- **Interventions to Support Occupations:** These include methods and tasks that prepare the client for occupational performance. Examples are the use of physical agent modalities (PAMs) to decrease pain, the construction of orthotics and prosthetics, and the assessment and selection of assistive technology.

### Passive Therapy Services

Passive therapy services involve treatments that are done to the patient without their active involvement. The document mentions:

- **Education and Training:** These interventions impart knowledge and information about occupation, health, well-being, and participation. Examples include providing education on home and activity modifications for caregivers and developing training programs for practitioners.
- **Advocacy:** Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources. Examples include collaborating with clients to procure reasonable accommodations at work and educating teachers about inclusive classroom design.

### Experimental Therapy Services

Experimental therapy services are those that are still being studied and are not yet widely accepted as standard treatments. The document discusses:

- **Self-Regulation:** These interventions target specific client factors or performance skills to promote emotional stability and executive functioning. Examples include participating in a fabricated sensory environment to promote alertness and consulting with businesses to establish sensory-friendly environments.
- **Virtual Interventions:** The use of technology such as telehealth and mobile health (mHealth) to plan, implement, and evaluate occupational therapy interventions. Examples include performing telehealth therapy sessions and developing methods and standards for mHealth in community occupational therapy practice.

## ANALYSIS OF EVIDENCE

Cohen, Searle et al, and the OT Practice Framework (4<sup>th</sup> Edition) all recognize the value of active therapy services, particularly exercise interventions, in managing pain and improving function. <sup>(1,2,5)</sup> They also agree that passive therapy services like electrotherapies and manipulative therapies are less effective compared to active exercise interventions. However, they differ in their emphasis on specific interventions and the inclusion of experimental therapies. The OT Practice Framework - 4th Edition provides a broader perspective on occupational therapy interventions, while Cohen and Searle et al. focus more on exercise and other physical interventions.

## POLICY HISTORY

Date	Summary
December 2025	<ul style="list-style-type: none"> <li>● This guideline merges and replaces the following guidelines:               <ul style="list-style-type: none"> <li>○ ECG 1500 for Active Procedures in Physical Medicine</li> <li>○ ECG 1503 for Experimental, Unproven, or Investigational Services</li> <li>○ ECG 1507 for Passive Treatment</li> </ul> </li> </ul>

## LEGAL AND COMPLIANCE

### Guideline Approval

#### Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

### Disclaimer

*Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.*

*Evolent Clinical Guidelines are comprehensive and inclusive of various procedural applications for each service type. Our guidelines may be used to supplement Medicare criteria when such criteria is not fully established. When Medicare criteria is determined to not be fully established, we only reference the relevant portion of the corresponding Evolent Clinical Guideline that is applicable to the specific service or item requested in order to determine medical necessity.*

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# Evolut Clinical Guideline 1504 for Measurable Progressive Improvement

<b>Guideline Number:</b> Evolut_CG_1504		
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## STATEMENT

### General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

### Purpose

This guideline provides minimal clinical thresholds using specific, measurable, and functional treatment goals and/or outcome measures in the determination of improved, lasting, and sustained outcomes. These thresholds will assist in medical necessity reviews of billed clinical services by network practitioners.

All recommendations in this guideline reflect practices that are evidence-based and/or supported by broadly accepted clinical specialty standards.

### Special Note

Outcome measures and pre-determined treatment goals (specific, measurable, and functional) must be used with each patient. These measures must be clearly defined in the patient record to ascertain the amount or degree of change over time and the documentation must provide evidence of lasting, sustainable progress with treatment.

## MEASURABLE IMPROVEMENT

### Defined

Meaningful clinical changes are calculated outcome measures using a standardized assessment tool. Using standardized assessment tools in the management of neuromusculoskeletal disorders follows Physical Medicines professional standards. These include:

- Minimal Clinically Important Change (MCIC)
- Minimal Clinically Important Differences (MCID)
- Minimal Detectable Change (MDC)
- Minimal Important Change (MIC)
- Maximum Therapeutic Benefit (MTB)

- Smallest Detectable Change (SDC)
- Standard Error of Measurement (SEM)
- Small Meaningful Change (SMC)
- Smallest Real Change (SRC)

## Scope

In determining meaningful progress toward goals (MCIC and MTB) the record must include documented relevant standardized outcome assessments. The calculated outcome measures can be used to set goals and determine treatment effectiveness. Progress towards goals should be assessed at predetermined time periods and supported by anticipated meaningful clinical change based on the treatment plan goals, e.g.:

- Recovery patterns for neuromusculoskeletal conditions involving the low back, neck, and headache disorders show that > 50% of the overall improvement with care occurs within 4 - 6 weeks
- When patients are categorized via predictive modeling, the percentage of those showing significant improvement within 6 weeks rises considerably <sup>(1)</sup>
- This organization requires all practitioner records must evaluate and document whether treatment is resulting in progressive and sustained improvement, including clear, specific, and measurable improvement in the patient's pain and function.
- Every two weeks or at regular intervals as appropriate for the documented condition
- Measured by one or more of the below methods for each anatomic region (listed below in Acceptable Thresholds) <sup>(2)</sup>
- If no functional tool is available for the patient's condition it is expected the practitioner will develop specific, measurable, and functional goals

## Acceptable Thresholds

### ***5 Times Sit to Stand Test (5XSTS)*** <sup>(3)</sup>

- Older Adults: 5 repetitions of this test exceeding the following can be considered to have worse than average performance
  - 11.4 s (60 to 69 years)
  - 12.6 s (70 to 79 years)
  - 14.8 s (80 to 89 years)
- MCID
  - Vestibular Disorders = 2.3 seconds
- MDC
  - Vestibular Disorders = 3.6 to 4.2 seconds

## **6-Minute Walk Test (6MWT) for Older Adults**

- MDC
  - Alzheimer's Disease: 33.5 m (110 feet) <sup>(4)</sup>
  - Hip Osteoarthritis or knee osteoarthritis that later received a total joint replacement: 61.34 m <sup>(5)</sup>
  - Huntington's Disease – chronic progressive <sup>(2)</sup>
    - Premanifest = 39.22 m
    - Manifest = 86.57 m
    - Early-stage = 56.6 m
    - Middle-stage = 126.14 m
    - Late-stage = 70.65 m
  - Multiple Sclerosis – chronic progressive: 88 m <sup>(2)</sup>
  - Multiple Sclerosis – chronic progressive = 20% <sup>(2)</sup>
  - Older Adults: 58.21 m <sup>(4)</sup>
  - Parkinson's Disease: 82 m <sup>(2,4)</sup>
  - Stroke – chronic: 34 – 37 m or 13% change <sup>(4)</sup>
  - Stroke – subacute: 61 m
- MIC
  - Multiple Sclerosis – chronic progressive (mild to severe): 21.56 m (patient anchor) <sup>(2)</sup>
  - Multiple Sclerosis – chronic progressive (mild to severe): 9.06 m (clinician anchor) <sup>(2)</sup>
  - Multiple Sclerosis – chronic progressive (deterioration): -53.35 m (patient anchor) <sup>(2)</sup>
  - Multiple Sclerosis – chronic progressive (deterioration): -55.06 m (clinician anchor) <sup>(2)</sup>
- SEM
  - Multiple Sclerosis – chronic progressive: 32 m <sup>(2)</sup>
  - Stroke – subacute: 22 m <sup>(2)</sup>
  - Stroke – chronic: 12 – 18 m <sup>(4)</sup>
- SMC
  - Older adults with limited mobility: 20 m (66 feet) <sup>(4)</sup>
  - Older adults with stroke: 22 m (72 feet)
  - Stroke – subacute: 21 m (anchor stairs) <sup>(2)</sup>
  - Stroke – subacute: 54 m (anchor-walk block) <sup>(2)</sup>
- SRC<sub>individual</sub>
  - Multiple Sclerosis – chronic progressive (mild to severe): 67.22 m (patient anchor) <sup>(2)</sup>

- Multiple Sclerosis – chronic progressive (mild to severe): 68.32 m (clinician anchor) <sup>(2)</sup>

### **10 Meter Walk Test (10MWT) <sup>(6)</sup>**

- Normative Values (m/s) - Healthy Adults
  - Men/Women (20s) = 1.358/1.341
  - Men/Women (30s) = 1.433/1.337
  - Men/Women (40s) = 1.434/1.390
  - Men/Women (50s) = 1.433/1.313
  - Men/Women (60s) = 1.339/1.241
  - Men/Women (70s) = 1.262/1.132
  - Men/Women (80/90s) = 0.968/0.943
- MDC
  - Huntington's Disease
    - Pre-manifest, comfortable = 0.23 m/s
    - Manifest, comfortable = 0.34 m/s
    - Early-stage, comfortable = 0.20 m/s
    - Middle-stage, comfortable = 0.46 m/s
    - Late-stage, comfortable = 0.29 m/s
  - Multiple Sclerosis = 0.26 m/s
  - Parkinson's Disease (comfortable) = 0.18 m/s
  - Parkinson's Disease (fast) = 0.25 m/s
  - Spinal Cord Injury (incomplete < 12 months) = 0.13 m/s
  - Stroke (acute) = 0.11 m/s
  - Stroke (chronic > 6 months, comfortable) = 0.18 m/s
  - Stroke (chronic > 6 months, fast) = 0.13 m/s
- MCID
  - Stroke (subacute) = 0.16 m/s

### **Activities of Daily Living Scale of the Knee Outcome Survey**

- MCID
  - = 7.1% <sup>(7)</sup>
- MDC
  - = 2.23 <sup>(8)</sup>

## **Activity-Specific Balance Confidence Scale (ABC)**

- MCID
  - Vestibular Disorders = 18.1% <sup>(9)</sup>
- MDC
  - Older Adults – 14.89 <sup>(10)</sup>
  - Parkinson's Disease = 11 – 13% <sup>(10,11)</sup>
  - Parkinson's Disease – chronic progressive = 13 <sup>(2)</sup>
  - Cerebral Vascular Accident = 14%
  - Chronic Stroke – 19.79 <sup>(10)</sup>
  - Chronic Incomplete Spinal Cord Injury – 14.87% <sup>(10)</sup>
  - Multiple Sclerosis – 9.86 <sup>(10)</sup>
- SEM
  - Parkinson's Disease – chronic progressive = 11% <sup>(2)</sup>
  - Parkinson's Disease = 4.01 <sup>(10)</sup>
  - Stroke – acute and chronic = 5.05 – 7.14 <sup>(10)</sup>
  - Older adults = 1.2 <sup>(10)</sup>
  - Lower Limb Loss – 0.21 <sup>(10)</sup>
  - Spinal Cord Injuries – 5.37% <sup>(10)</sup>
  - Multiple Sclerosis – 4.07 – 5.03 <sup>(10)</sup>
  - Cerebral Palsy – 6.53 <sup>(10)</sup>
- SMC
  - Older adults = 7 points

## **Berg Balance Scale (BBS)**

- MIC <sup>(2)</sup>
  - Multiple Sclerosis: deterioration (clinician anchor) = -0.60
  - Multiple Sclerosis: deterioration (patient anchor) = -1.41
- MCID <sup>(12)</sup>
  - Subacute stroke (assisted walking): 5 points
  - Subacute stroke (unassisted walking): 4 points
- MDC
  - = 6.2 – 6.5 points <sup>(13)</sup>
  - Alzheimer's Disease and Progressive Dementia = 1.92 <sup>(14)</sup>

- Huntington's Disease <sup>(2)</sup>
  - Chronic progressive premanifest = 1
  - Chronic progressive manifest = 5
  - Chronic progressive early-stage = 4
  - Chronic progressive middle-stage = 5
  - Chronic progressive late-stage = 5
- Older adults = 8 – 10.5 points <sup>(14,15)</sup>
- Parkinson's Disease = 5 points <sup>(2)</sup>
- Stroke (acute) = 6 (90%) <sup>(2)</sup>
- Stroke (acute) = 7 (95%) <sup>(2)</sup>
- Stroke (chronic) = 2.7 points <sup>(14)</sup>
- Stroke (chronic/stable) = 4.66 – 6.7 <sup>(2)</sup>
- SEM
  - Alzheimer's Disease and Progressive Dementia = 0.97 <sup>(14)</sup>
  - Stroke (acute) = 2.49 <sup>(2)</sup>
  - Stroke (chronic/stable) = 1.49 – 2.4 <sup>(2)</sup>
  - Traumatic Brain Injury = 1.65 <sup>(16)</sup>

### ***Bournemouth – Back Questionnaire*** <sup>(17)</sup>

- Acute: change of 26 points
- Chronic: change of 18 points

**NOTE:** It is recommended that the Bournemouth be used at baseline and for every 2 - 4 weeks or 6 - 12 visits thereafter within the treatment program to measure progress

### ***Bournemouth – Neck Questionnaire*** <sup>(18)</sup>

- A change of 13 points or 36% is considered clinically significant improvement

**NOTE:** It is recommended that the Bournemouth be used at baseline and for every 2 - 4 weeks or 6 - 12 visits thereafter within the treatment program to measure progress

### ***Bruininks-Oseretsky Test of Motor Proficiency, 2nd Edition (BOT™-2)*** <sup>(19)</sup>

- MCID
  - Children aged 3-6 years with intellectual disability
    - = 6.5 (BOT™-2-SF Standard Scores)
  - Children aged 4-21 years with intellectual disability

- = 6.5 (aged 4-12 years) (BOT™-2-SF standard scores)
  - = 7.4 (aged 13-21 years) (BOT™-2-SF standard scores)
  - Balance subtest: children with Cerebral Palsy = 2.54 <sup>(20)</sup>
- MDC
  - Children aged 3-6 years with intellectual disability
    - = 7.4 (BOT™-2-SF Standard Scores)
  - Children aged 4-21 years with intellectual disability
    - = 4.2 (aged 4-12 years) (standard scores)
    - = 7.4 (aged 13-21 years) (standard scores)
  - Children aged 7-10 with fetal alcohol syndrome
    - = 6.1 (BOT™-2-SF Raw scores)
    - Balance subtest: children with Cerebral Palsy = 9.61
- SEM
  - Children aged 3-6 years with intellectual disability
    - = 1.6 (BOT™-2-SF standard scores)
  - Children aged 7 – 9 years with fetal alcohol disorders = 2.2 (BOT™-2-SF raw score) / 2.1 (BOT™-2-SF standard score)
  - Balance subtest in children with Cerebral Palsy = 0.70

### ***Disability of Arm, Shoulder, and Hand (DASH)***

- MCID <sup>(21)</sup>
  - Elbow Arthroplasty (much worse or much better) = 19 points
  - Elbow Arthroplasty (somewhat better or somewhat worse) = 10 points
  - Elbow Arthroplasty (no change) = -3 points
  - Musculoskeletal Upper Extremity (Adults) = 10.2
- MDC
  - Humeral Joint Pain and Fractures = 16.1 (DASH) <sup>(21)</sup>
  - Musculoskeletal Upper Extremity (Adults) = 10.7 – 12.2 (90% CI) <sup>(21)</sup>
  - Musculoskeletal Upper Extremity (Adults) = 12.75 (95%CI) <sup>(21)</sup>
  - Shoulder = 10.7% (90%CI) <sup>(22)</sup>
  - Shoulder = 12.75% (95%CI) <sup>(22)</sup>
- SEM
  - Humeral Joint Pain and Fractures = 5.82 (DASH) <sup>(21)</sup>

- Musculoskeletal Upper Extremity (Adults)= 4.6 – 5.22 <sup>(21)</sup>
- Osteoarthritis = 2.27 (DASH 0-3\*) <sup>(21,23)</sup>
- Osteoarthritis = 3.26 (DASH 0-6\*) <sup>(21,23)</sup>
- Osteoarthritis = 4.49 (DASH 0-12\* Osteoarthritis) <sup>(21,23)</sup>

**NOTE:** \*Paired differences of the DASH score; DASH 0 is mean score preoperative, DASH 3 is mean score at 3 months, DASH 6 is mean score at 6 months, and DASH 12 is mean score at 12 months.

### ***Disability of Arm, Shoulder, and Hand (QuickDASH)*** <sup>(24)</sup>

- MCID
  - Upper Extremity (whole) = 8 points
- MDC
  - = 11 – 17.2 points (90%CI)
  - = 20.4 points (95%CI)
- SEM
  - = 6.43 (very much improved)
  - = 3.26 (much improved)
  - = 3.37 (minimally improved)
  - = 10.22 (no change)

### ***Dizziness Handicap Inventory (DHI)***

- MCID
  - Benign Paroxysmal Positional Vertigo = decrease from 18.05 at the first day to 9.54 at 30 days <sup>(25)</sup>
  - Vestibular Disorders = change of 18 points (95% CI, pretreatment and posttreatment scores difference) <sup>(25,26)</sup>
- MDC
  - Multiple Sclerosis = 22.50 <sup>(25)</sup>
  - Vestibular Disorders = 17.18 points <sup>(26)</sup>
- SEM
  - Vestibular Disorders = 6.2 <sup>(25,26)</sup>

### ***Dynamic Gait Index (DGI)***

- MDC
  - Multiple Sclerosis = 4.19 – 5.54 <sup>(27)</sup>

- Stroke = 4 points <sup>(27)</sup>
- Stroke (change) = 16.6% <sup>(27)</sup>
- Stroke (chronic) = 2.6 points <sup>(27)</sup>
- Parkinson's Disease = 13.3% <sup>(27,28)</sup>
- Parkinson's Disease and Older Adults = 2.9 points <sup>(27,28)</sup>
- Vestibular Disorders = 3.2 points <sup>(27,29)</sup>
- SEM
  - Older Adults = 1.04 points <sup>(27)</sup>
  - Multiple Sclerosis (inter-rater reliability) = 1.51 points <sup>(27)</sup>
  - Multiple Sclerosis (intra-rater reliability) = 2.00 points <sup>(27)</sup>
  - Stroke (chronic) = 0.71 <sup>(27)</sup>
  - Stroke (inter-rater reliability) = 0.94 <sup>(30)</sup>
  - Stroke (test-retest condition) = 0.97 <sup>(30)</sup>
  - Vestibular Disorders = 2.8 points <sup>(27,29)</sup>

### ***Falls Self Efficacy Scale/Falls Efficacy Scale-International (FES-I)*** <sup>(31)</sup>

- MDC
  - Multiple Sclerosis = 0.52 points
  - Older Adult (Hip fracture) = 17.7 points <sup>(32)</sup>
  - Vestibular Disorders = 8.2 points
- SEM
  - Multiple Sclerosis = 0.19 points
  - Older Adult (Hip Fracture) = 6.4 points <sup>(32)</sup>
  - Vestibular Disorders = 3.0 points

### ***Foot and Ankle Ability Measures (FAAM)*** <sup>(33,34)</sup>

- MCID
  - Activities of Daily Living (subscale) = 8% points
  - Sport (subscale) = 9% points
- MDC
  - Activities of Daily Living (subscale 95% CI) = 5.7
  - Sports (subscale 95% CI) = 12.3
- SEM
  - Activities of Daily Living (subscale) = 2.1

- Sports (subscale) = 4.5

### ***Fear Avoidance Belief Questionnaire (FABQ)***

- MCIC
  - Arthroscopic subacromial decompression (following) = -5.0 <sup>(35)</sup>
- MCID <sup>(36)</sup>
  - Lower Back Pain = 13 points
  - Physical Activity (Pelvic Girdle Pain) = 25%
- MDC
  - Low back pain = -5.4
  - Physical Activity (Pelvic Girdle Pain) = 6.1 <sup>(36)</sup>
  - Physical Activity (Subscale) = 12 points <sup>(37)</sup>
  - Physical Activity (Worker UE injury) = 8 points (change scores equivalent to 30-33% of scale) <sup>(36)</sup>
  - Work (Subscale) = 9 points <sup>(37)</sup>
- SEM
  - Physical Activity (Pelvic Girdle Pain) = 2.20 <sup>(36)</sup>

### ***Functional Gait Assessment (FGA)*** <sup>(38)</sup>

- MCID
  - Older Adults = 4 points (from interim to end of care) <sup>(39)</sup>
  - Vestibular Disorders = 4 points <sup>(9)</sup>
  - Vestibular Disorders = 18.1%
- MDC
  - Parkinson's Disease = 4 points <sup>(39)</sup>
  - Stroke (acute and chronic) = 4.2 <sup>(39)</sup>
  - Stroke (acute and chronic) = 14.1% <sup>(39)</sup>
  - Vestibular Disorders (acute) = 6 points (95% CI) <sup>(2)</sup>
- SEM
  - Stroke = 1.52 <sup>(39)</sup>

### ***Functional Rating Index (FRI)*** <sup>(40)</sup>

- MCID
  - Spinal musculoskeletal system = 8.4 points

**NOTES:**

- Acute and subacute conditions: recommended the FRI be used at baseline and every 1 week or 3 visits thereafter
- Chronic conditions: recommended the FRI be used at baseline and every 2 weeks or 6 visits thereafter
- If the score does not improve by at least 10% (absolute change) in any two successive two-week periods, you should pursue a change in management

**Functional Status (FS) Measure or FOTO** <sup>(41,42)</sup>

- The MCII (Minimally Clinically Important Improvement) and MDC are stated on the assessment report
  - For significant, minimal improvement, the patient status should increase by the MDC value

**NOTE:** FOTO summary report is available upon request

**Gait Speed for Adults** <sup>(43–45)</sup>

- MCID
  - Joint pain and fractures = 0.1 m/s
  - Older Adults = 0.05 – 0.12 m/s
  - Older Adults with Heart Failure = 0.05 – 0.12 m/s
  - Chronic Obstructive Pulmonary Disease = 0.11 m/s (anchored against ISW)
  - Chronic Obstructive Pulmonary Disease = 0.08 m/s (anchored against self-reported improvement)
  - Stroke = 0.1 m/s
  - Vestibular Disorders = 0.09 m/s <sup>(9)</sup>
- MDC
  - Heart Failure = 0.05 m/s
  - Joint pain and fractures = 0.08 m/s
  - Older Adults = 0.05 m/s
  - Pulmonary Diseases (Chronic Obstructive Pulmonary Disease) = 0.11 m/s (95% CI)
- Meaningful change for those with stroke undergoing rehab = 0.175 m/s
- SEM
  - Pulmonary Diseases (Chronic Obstructive Pulmonary Disease) = 1.14% (Interobserver)
  - Pulmonary Diseases (Chronic Obstructive Pulmonary Disease) = 1.5% (Test-retest reliability)

- SMC = 0.5 m/s
- Substantial meaningful change = 0.10 m/s

### **Global Rating of Change (GRoC)**

(<sup>‡</sup>See Note below)

- MCIC
  - 2 points on 11-point scale
- MDC
  - 0.45 points on 11-point scale
- MIC
  - Low Back Pain = 2.5 points on 11-point scale <sup>(46)</sup>

### **<sup>‡</sup>NOTE: Questionable Outcome tool: Global Rating of Change (GRoC)**

Further work is needed to determine the true value of the GRoC as an outcome measure and in turn as an anchor measure. Several key points have been identified <sup>(47)</sup>:

- There is fluctuant temporal stability of the GRoC from week to week
- There is poor correlation between the GRoC and functional measures
- The GRoC is only correlated to functional measures up to 3 weeks

### **Goal Attainment Scale (GAS) <sup>(48)</sup>**

- MDC
  - Cerebral Palsy (Pediatric) = 2.040 (Low Response Group)
  - Cerebral Palsy (Pediatric) = 1.275 (High Response Group)
- SEM
  - Cerebral Palsy (Pediatric) = 0.736 (Low Response Group)
  - Cerebral Palsy (Pediatric) = 0.460 (High Response Group)

### **Gross Motor Function Measure-66 (GMFM-66) <sup>(49)</sup>**

- Clinically meaningful improvement <sup>(50)</sup>
  - = 1.58
- MCID
  - Cerebral Palsy <sup>(51)</sup>
    - Gross Motor Function Classification System Level I: 1.7 -2.7
    - Gross Motor Function Classification System Level II: 1.0-1.5
    - Gross Motor Function Classification System Level III: 0.7 – 1.2

- Gross Motor Function Classification System Level Overall: 0.8 – 1.3

### **Headache Disability Inventory (HDI)** <sup>(52)</sup>

- Decrease of 29 points (95% CI) or more is considered clinically significant

### **Keele STarT Back Screening Tool** <sup>(53,54)</sup>

- High-risk categories: > 4 (psychosocial subscale scores)
- Medium-risk categories: > 3 (overall tool score) and < 4 (psychosocial subscale scores)
- Low-risk categories: < 3 (overall tool score)

**NOTE:** No MDC or MCID established

### **Knee Injury and Osteoarthritis Outcome Score (KOOS)**

- MDC
  - Athletes <sup>(55)</sup>
    - Pain = 6.1
    - Symptoms = 8.5
    - Activities of Daily Living = 8.0
    - Sports/Rec = 5.8
    - Quality of Life = 7.2
  - Joint Pain and Fractures = 8 – 10-point change may represent minimal perceptible clinical improvement <sup>(55)</sup>
  - Knee Ligament Injury
    - Anterior Cruciate Ligament Reconstruction in Athletic Populations (KOOS subscales) <sup>(56)</sup>
      - Symptoms = 8.5
      - Pain = 6.1
      - Activities of Daily Living = 8.0
      - Sports/recreation = 5.8
      - Quality of Life = 7.2
    - Articular Cartilage Lesion (KOOS subscales) <sup>(56)</sup>
      - Symptoms = 11.8
      - Pain = 11.2
      - Activities of Daily Living = 11.1
      - Sports/recreation = 12.1
      - Quality of Life = 8.7

- Focal Cartilage Repair (KOOS subscales) <sup>(56)</sup>
  - Symptoms = 5
  - Pain = 6
  - Activities of Daily Living = 7
  - Sports/recreation = 12
  - Quality of Life = 7
- Osteoarthritis and No Indication for Joint Replacement (KOOS subscales) <sup>(56)</sup>
  - Symptoms = 15.5
  - Pain = 13.4
  - Activities of Daily Living = 15.4
  - Sports/recreation = 19.6
  - Quality of Life = 21.1
- Meniscal Injury (with and without surgery) (KOOS subscales) <sup>(56)</sup>
  - Symptoms = 19.4
  - Pain = 25.7
  - Activities of Daily Living = 20.2
  - Sports/recreation = 35.0
  - Quality of Life = 26.2
- Osteoarthritis and Joint Replacement = 8 – 10-point change may represent minimal perceptible clinical improvement <sup>(55)</sup>
- Younger individuals (KOOS subscales) = 14.3 – 19.6 points <sup>(57)</sup>
- Older individuals (KOOS subscales) =  $\geq 20$  points <sup>(57)</sup>
- MCID
  - Knee
    - Arthroplasty (total knee, post)
      - Function = 15.
      - Pain = 13.5 2
      - Quality of Life = 8.0
    - Autologous Chondrocyte Implantation (KOOS subscale) <sup>(56)</sup>
      - Symptoms = could not be calculated
      - Pain = 11 – 18.8
      - Activities of Daily Living = 2 – 17.3
      - Sports/recreation = 5 – 18.6

- Quality of Life = 8 – 19.6
  - Meniscal repair (Post arthroscopic) <sup>(58)</sup>
    - Symptoms = 12.3
    - Pain = 11.8
    - Activities of Daily Living = 11.4
    - Sports/recreation = 16.7
    - Quality of Life = 16.9
  - Osteochondral Allograft Transplantation (KOOS subscales) <sup>(56)</sup>
    - Symptoms = could not be calculated
    - Pain = 7
    - Activities of Daily Living = could not be calculated
    - Sports/recreation = 25
    - Quality of Life = could not be calculated
  - Platelet-rich plasma Injection Treatment <sup>(59)</sup>
    - 6 months after (KOOS subscales)
      - ◆ Symptoms = 8.4
      - ◆ Pain = 9.3
      - ◆ Activities of Daily Living = 9
      - ◆ Sports/recreation = 12.5
      - ◆ Quality of Life = 10.3
    - 12 months after (KOOS subscales)
      - ◆ Symptoms = 8.2
      - ◆ Pain = 9.1
      - ◆ Activities of Daily Living = 9.2
      - ◆ Sports/recreation = 11.6
      - ◆ Quality of Life = 10.3
- SEM <sup>(56)</sup>
  - Athletes (mean age 25.6 ± 3.4 years)
    - Pain = 2.2
    - Symptoms = 3.1
    - Activities of Daily Living = 2.9
    - Sports/Rec = 2.1
    - Quality of Life = 2.6

- Knee Ligament Injury
  - Anterior Cruciate Ligament Reconstruction in Athlete (KOOS subscales)
    - Symptoms = 3.1
    - Pain = 2.2
    - Activities of Daily Living = 2.9
    - Sports/recreation = 2.1
    - Quality of Life = 2.6
  - Anterior Cruciate Ligament Tear Within 1 Year or Anterior Cruciate Ligament Repair Within 1 Year (KOOS subscales)
    - Symptoms = 9.1
    - Pain = 6.6
    - Activities of Daily Living = 7.8
    - Sports/recreation = 12.7
    - Quality of Life = 7.6
  - Articular Cartilage Lesion: Autograft Implantation System (KOOS subscales)
    - Symptoms = 11.1
    - Pain = 9.50
    - Activities of Daily Living = 10.7
    - Sports/recreation = 10.8
    - Quality of Life = 7.4
  - Meniscal Injury (with/without Meniscal Surgery) (KOOS subscales)
    - Symptoms = 7.0
    - Pain = 9.3
    - Activities of Daily Living = 7.3
    - Sports/recreation = 12.6
    - Quality of Life = 9.5
- Knee Osteoarthritis (KOOS subscales)
  - Mild Osteoarthritis with Anterior Cruciate Ligament Reconstruction
    - Symptoms = 9.0
    - Pain = 7.2
    - Activities of Daily Living = 5.2
    - Sports/recreation = 9.0
    - Quality of Life = 7.4

- Moderate Osteoarthritis with High Tibial Osteotomy and Valgus Correction (KOOS subscales)
  - Symptoms = 8.0
  - Pain = 9.0
  - Activities of Daily Living = 5.8
  - Sports/recreation = 11.6
  - Quality of Life = 7.4
- Osteoarthritis with TKA Revision (KOOS subscales)
  - Symptoms = 7.2
  - Pain = 10.1
  - Activities of Daily Living = 11.7
  - Sports/recreation = 24.6
  - Quality of Life = 10.8

### ***Knee Injury and Osteoarthritis Outcome Score for Children (KOOS-Child)***

- SEM
  - Children with Knee Disorders <sup>(60)</sup>
    - Pain = 5.69
    - Symptoms = 8.14
    - Activities of Daily Living = 5.28
    - Sports/play = 8.02
    - Quality of Life = 7.59
  - Children with Stable Knee Conditions <sup>(61)</sup>
    - Pain = 9.9
    - Symptoms = 10.2
    - Activities of Daily Living = 8.9
    - Sports/play = 16.9
    - Quality of Life = 10.5
- MDC
  - Children with Knee Disorders <sup>(60)</sup>
    - Pain = 15.78
    - Symptoms = 22.56
    - Activities of Daily Living = 14.64

- Sports/play = 22.22
- Quality of Life = 21.03
- Children with Stable Knee Conditions <sup>(61)</sup>
  - Pain = 27.3
  - Symptoms = 28.4
  - Activities of Daily Living = 24.7
  - Sports/play = 46.9
  - Quality of Life subscale = 29.2

### ***Knee Outcome Survey (KOS)***

- MCID <sup>(7)</sup>
  - Activities of Daily Living = 7.1 percentage points change
- MDC <sup>(62)</sup>
  - = 11.4

### ***Lower Extremity Functional Scale (LEFS)***

- MCID
  - Ankle Sprains = 4 points <sup>(63)</sup>
  - Joint Pain and Fractures <sup>(64)</sup>
    - Anterior Cruciate Ligament reconstruction = 9 points
    - Arthroplasty
      - Total knee = 9 points
      - Total hip = 9 points
    - Hip Impairment = 6 points or 11.3%
    - Lower Extremity Injury = 9 points
  - Knee <sup>(65)</sup>
    - Osteoarthritis = 6.3 points (0-2 months)
    - Osteoarthritis = 7.5 points (0-6 months)
    - Osteoarthritis = 12.5 points (0-12 months)
  - Lower extremity musculoskeletal dysfunction = 9 points <sup>(65)</sup>
- MDC
  - Ankle Sprains = 4 points <sup>(63)</sup>
  - Joint Pain and Fractures <sup>(64)</sup>
    - Anterior Cruciate Ligament reconstruction = 8.7 points

- Arthroplasty
      - Total knee = 9 points
      - Total hip = 9 points
    - Hip Impairment = 7 points or 11.3%
    - Lower Extremity Injury = 9 points
  - Knee <sup>(65)</sup>
    - Anterior knee pain = 8 points
    - Osteoarthritis = 19.2 points (at 2 months)
    - Osteoarthritis = 17.6 points (at 6 months)
    - Osteoarthritis = 22.6 points (at 12 months)
    - Total knee arthroplasty = 9 points
  - Lower extremity musculoskeletal dysfunction = 9 points <sup>(65)</sup>
  - Osteoarthritis
    - Hip = 9.9 – 10 points <sup>(65,66)</sup>
    - Lower extremity = 9 points
- SEM
  - Ankle Sprains = 4 points <sup>(63)</sup>
  - Chronic Pain (Orthopaedic Rehab) = 4 points
  - Joint Pain and Fractures <sup>(64)</sup>
    - Anterior Cruciate Ligament reconstruction = 3.7 points
    - Arthroplasty
      - Total knee = 3.7 points
      - Total hip = 3.7 points
    - Lower Extremity Injury = 3.9 points
    - Orthopaedic Rehab = 4 points
  - Knee <sup>(65)</sup>
    - Anterior knee pain = 0.10 points
    - Osteoarthritis = 3.4 points
    - Osteoarthritis = 6.9 points (at 2 months)
    - Osteoarthritis = 6.4 points (at 6 months)
    - Osteoarthritis = 8.2 points (at 12 months)
    - Total knee arthroplasty = 3.7 points
  - Osteoarthritis

- Hip = 3.6 – 5.3 points <sup>(66)</sup>
- Orthopaedic Rehab = 4 points
- **NOTE:** It is recommended that the LEFS be used at baseline and for every 2 - 4 weeks or 6 - 12 visits thereafter within the treatment program to measure progress

### ***Lysholm Knee Rating System*** <sup>(62)</sup>

- MDC
  - Knee Injuries (Anterior Cruciate Ligament, meniscal, chondral, patellar dislocation) = 8.9 – 10.1
- SEM
  - Knee Injuries (Anterior Cruciate Ligament, meniscal, chondral, patellar dislocation) = 3.2 – 3.6

### ***Neck Disability Index (NDI)***

- MCID
  - Cervical radiculopathy = 7.0 – 8.5 points <sup>(67,68)</sup>
  - Cervical spine fusion = 7.5 points <sup>(67)</sup>
  - Mechanical neck disorders = 5 – 7.5 points <sup>(67)</sup>
  - Mechanical neck disorders = 19% <sup>(67)</sup>
  - Mechanical neck pain = 7.5 points <sup>(68)</sup>
  - Neck Pain (non-specific) = 3.5 points <sup>(67)</sup>
- MDC
  - Cervical radiculopathy = 10.2 – 13.4 points <sup>(67)</sup>
  - Mechanical neck disorders = 10.2 points <sup>(67)</sup>
  - Mechanical neck disorders = 19.6% <sup>(67)</sup>
  - Mechanical pain = 10.2 points <sup>(68)</sup>
  - Neck pain = 5 points (90% CI) <sup>(69)</sup>
  - Neck Pain (non-specific) = 8.4 – 10.5 points <sup>(67)</sup>
- SEM
  - Cervical Radiculopathy = 4.4 – 5.7 points <sup>(67)</sup>
  - Mechanical Neck Disorder = 4.3 – 8.4 points <sup>(67)</sup>
  - Neck Pain (non-specific) = 3.0 points <sup>(67)</sup>

**NOTE:** It is recommended that the Neck Disability Index be used at baseline and for every 2 weeks thereafter within the treatment program to measure progress.

**NOTE:** A score of 0% - 20% represents a minimal disability; usually, no treatment is indicated except for advice on posture, physical fitness, and diet. Patients often do not score the Neck Disability items as zero, once they are in treatment. The practitioner should consider the patient's prior level of function when goal writing (e.g., the patient's prior level of function would place them in the minimal disability category, their goal should not be to obtain a zero score).

### **Numeric Pain Rating Scale (NPRS)** <sup>(70,71)</sup>

- MCID <sup>(70)</sup>
  - Emergency Room (acute pain) = 1.3 points <sup>(70)</sup>
  - Low Back Pain (1 week of physical therapy) = 1.5 points
  - Low Back Pain (4 weeks of physical therapy) = 2.2 points
  - Musculoskeletal Pain (Chronic) = 1 point or 15% change
  - Chronic Pain (other; low back pain, osteoarthritis, diabetic neuropathy, post-herpetic neuralgia, fibromyalgia) = 1.7 points or reduction of 27.9%
  - Shoulder Pain = 2.17 points (surgical and nonsurgical subjects after 3-4 week of rehabilitation)
  - Spinal cord injuries (Chronic) = 1.6 – 1.80 points or 36% <sup>(70,71)</sup>
- MDC <sup>(70)</sup>
  - Low Back Pain = 2 points (95% CI)
- SEM <sup>(70)</sup>
  - Low Back Pain = 1.02

### **Oswestry Disability Index (ODI)** <sup>(72)</sup>

- MCIC
  - Lower back = 10 points or a 30% improvement
- MCID <sup>(73)</sup>
  - Low back pain (anchor based, ROC) = 7.5% - 16.7%
  - Lumbar Spine Surgery (anchor based (HTI)) = 9.5 – 15.4 points
  - Lumbar Spine Surgery (anchor based (ROC)) = 11.8 – 17.9 points
  - SI Joint Fusion Surgery (anchor based (HTI)) = 19.5% average change
  - SI Joint Fusion Surgery (ROC) = 12.2% - 15.0%
  - Spinal Deformity Surgery = 15.0%
- MDC
  - Back pain = 5.9 – 6.4 points (90% CI) <sup>(73)</sup>
  - Low back pain (subacute and chronic) = 11.1 – 15.35 (95% CI) <sup>(74)</sup>
  - Lumbar fusion = 11.7% - 15.5 % (90-95% CI) <sup>(73)</sup>

- SEM <sup>(73)</sup>
  - Back pain (mean duration 6 years) = 4.2 – 4.6 points
  - Low/upper back pain (< 1 year) = 2.6% - 2.8%
  - Spinal stenosis = 6.1%

**NOTE:** It is recommended that the Oswestry Disability Index be used at baseline and for every 2 weeks thereafter within the treatment program to measure progress.

**NOTE:** A score of 0% -20% represents a minimal disability; usually no treatment is indicated apart from advice on lifting, sitting posture, physical fitness, and diet. Patients often do not score the Oswestry items as zero once they are in treatment. The practitioner should consider the patient's prior level of function when goal writing (e.g., if the patient's prior level of function would place them in the minimal disability category, their goal should not be to obtain a zero score).

### ***Pain Disability Index*** <sup>(75)</sup>

- MCIC
  - Low Back Pain (chronic) = decrease of 8.5 - 9.5 points

### ***Patient Specific Functional Scale (PSFS)*** <sup>(76–78)</sup>

- MCID <sup>(77)</sup>
  - Humeral fracture (proximal) = 2 or more points
  - Knee arthroplasty (total) = 3.83 – 5.13
  - Osteoarthritis (hand) = 2.2-point change
  - Spinal Stenosis = 1.34 points
  - Upper Extremity Musculoskeletal = 1.2 points
- MDC
  - Chronic pain = 2 points <sup>(77)</sup>
  - Knee dysfunction = 1.5 <sup>(77)</sup>
  - Low Back pain = 1.4 points <sup>(77)</sup>
  - Lower Limb Amputees = 11.2 (90% CI) <sup>(77)</sup>
  - Neck Dysfunction and Whiplash = 2 points <sup>(77)</sup>
  - Older adults = 2.8 <sup>(77)</sup>
  - Osteoarthritis (hand) = 1.30 (90% CI) 1.56 (95% CI) <sup>(77)</sup>
  - Single activity score = 3 points (90% CI)
  - Spinal Stenosis = 2.4 points <sup>(77)</sup>
- SEM
  - Chronic pain = 0.41 <sup>(77)</sup>

- Knee dysfunction = 0.62 – 1.0 <sup>(77)</sup>
- Knee arthroplasty (total, 3 months post-surgery) = 1.38 – 1.85 <sup>(77)</sup>
- Lower Limb Amputees = 4.8 <sup>(77)</sup>
- Neck dysfunction or pain = 0.43 <sup>(76,77)</sup>
- Older Adults = 1.0 <sup>(77)</sup>
- Osteoarthritis (hand) = 0.56 <sup>(77)</sup>
- Spinal Stenosis = 1.03 <sup>(77)</sup>

**NOTE:** It is recommended that the PSFS be used at baseline and for every 2-4 weeks or 6-12 visits thereafter within the treatment program to measure progress

### ***Peabody Developmental Motor Scales-2nd Edition (PDMS-2)*** <sup>(79)</sup>

- MCID <sup>(80,81)</sup>
  - Intellectual disabilities (includes preschoolers) = 8.39
- MDC <sup>(80,81)</sup>
  - Intellectual disabilities (includes preschoolers) = 7.76
- SEM
  - Cerebral Palsy <sup>(80,81)</sup>
    - Fine Motor Quotient = 2.5
    - Gross Motor Quotient = 1.1
    - Total Motor Quotient = 1.6
  - Intellectual Disability = 1.80 <sup>(80)</sup>

### ***Pediatric Balance Scale*** <sup>(82)</sup>

- MDC:
  - Cerebral Palsy
    - Dynamic = 0.96 points
    - Static = 0.79 points
    - Total = 1.59 points
- MDIC
  - Cerebral Palsy
    - Dynamic 2.92
    - Static 2.92
    - Total 5.83

### ***Pediatric Evaluation of Disability Inventory (PEDI)*** <sup>(83)</sup>

- MCID
  - Traumatic Brain Injury, Spinal Cord Injury, Lower Extremity Trauma, Non-traumatic Brain Injury, Developmental Disorders
    - = 11 points (mean; all 6 scales)
    - = 11.3 (mean; for Likert Scale categories)
    - Caregiver Assistance
      - = 11.6 (Lickert Scale with range 8.7-14.9)
    - Functional Skills
      - = 10.9 (Lickert Scale with range 8.7-14.9)
    - Visual Analog Scale (VAS)
      - = 11.5 (mean)
      - = 11.2 (Caregiver Assistance with range 6.0-15.6)
      - = 11.6 (Functional Skills with range 6.0-15.6)

### ***Roland-Morris Disability Questionnaire (RMDQ)*** <sup>(84,85)</sup>

- MCID <sup>(84)</sup>
  - Low Back Pain
    - Acute, subacute, or chronic = 3.5 points
    - Detect change = 3 points or 30% of baseline score
    - Score > 7 then = 3 points
    - Score < 7 then = 30% change in score
    - Treatment of 3-6 weeks = 5-point change
- MDC <sup>(85)</sup>
  - = 7.6 points or a 30% improvement from baseline
- SEM <sup>(84)</sup>
  - Low Back Pain = 1.79
  - Lumbar Disc Surgery (post) = 2.0 scale points (95% CI)

**NOTE:** It is recommended that the RMDQ be used at baseline and for every 2-4 weeks or 6-12 visits thereafter within the treatment program to measure progress.

### ***Roll Evaluation of Activities of Life (REAL)*** <sup>(86)</sup>

- MDC
  - Children without Disabilities (Ages 2-18)

- ADL = 15.91
- IADL = 11.08
- SEM
  - Children without Disabilities (Ages 2-18)
    - Activities of Daily Living
      - Average = 5.74
      - Preschool = 1.41
      - Elementary = 3.00
      - Preadolescent = 2.45
      - Teenage = 4.00
    - Independence with Activities of Daily Living
      - Average = 4.00
      - Preschool = 1.73
      - Elementary = 2.00
      - Preadolescent = 1.41
      - Teenage = 2.65
  - Mean Standard Scores
    - Children with Disabilities
      - Attention Deficit Disorders: 85.08
      - Autism Spectrum Disorder: 54.53
      - Cerebral Palsy: -6.17
      - Children with Disabilities: 67.14
      - Developmental Delay: 60.34
      - Down Syndrome: 55.17
      - Learning Disabled: 76.32
      - Sensory Integration Disorders: 88.86
      - Speech Delay: 99.53

### ***Shoulder Pain and Disability Index (SPADI)***

- MCID
  - Musculoskeletal Upper Extremity Problems = 13.2 <sup>(87)</sup>
  - Pain Upper Extremity = 8 – 10 points <sup>(87,88)</sup>
  - Rotator Cuff Disease = 15.4 <sup>(87)</sup>

- MDC <sup>(87)</sup>
  - Adhesive Capsulitis = 17
  - Arthroplasty (shoulder) = 18
  - Musculoskeletal Upper Extremity Problems = 18.1
  - Shoulder Disorders = 21.5
- MIC
  - Shoulder pain = 20 points (43% of baseline) <sup>(89)</sup>
- SEM
  - Arthroplasty (shoulder) = 2 <sup>(88)</sup>
  - Non-specific population = 4.75 – 11.65 <sup>(87)</sup>
- SDC
  - Shoulder pain = 19.7 points <sup>(89)</sup>

**NOTE:** It is recommended that the SPADI be used at baseline and for every 2 - 4 weeks or 6 - 12 visits thereafter within the treatment program to measure progress

### ***Simple Shoulder Test (SST)***

- MCID
  - Arthroplasty (anatomic total shoulder) (aTSA) = 1.6 <sup>(90)</sup>
  - Arthroplasty (Ream-and-run) (R&R) = 2.6 <sup>(90)</sup>
  - Arthroplasty (Reverse total shoulder) (rTSA) = 3.7 <sup>(90)</sup>
  - Arthroplasty (shoulder) = 2.4 – 3.0 <sup>(91)</sup>
  - Rotator cuff disease = 8.5 – 9.7 <sup>(91)</sup>
- MDC <sup>(91)</sup>
  - Musculoskeletal (shoulder) = 32.3 (95% CI)
- SEM <sup>(91)</sup>
  - Musculoskeletal (shoulder) = 4.75 -11.65

### ***Timed Up and Go (TUG)***

- Cut-off score indicating risk of falls <sup>(92)</sup>
  - Adults  $\geq$  13.5 s
  - Lower extremity amputees  $\geq$  19 s
  - Older adults (fall clinic)  $\geq$  15 s
  - Older adults (frail)  $\geq$  32.6 s
  - Osteoarthritis (hip)  $\geq$  10 s

- Parkinson's Disease  $\geq 7.95 - 11.5$  s
- Stroke (older adults)  $\geq 14$  s
- Vestibular disorders  $\geq 11.1$  s
- MCID
  - Lumbar degenerative disc disease (post-surgery) = 2.1 s (or TUG z score change of 1.5) <sup>(93)</sup>
- MDC
  - Alzheimer's disease = 4.09 s <sup>(92)</sup>
  - Arthroplasty (Total hip) = 1.62 s (95% CI) <sup>(94)</sup>
  - Parkinson's Disease = 3.5 – 11 s <sup>(92,95)</sup>
  - Spinal cord injury = 10.8 s (30% difference) <sup>(92,95)</sup>
  - Stroke (chronic) = 2.9 s <sup>(92)</sup>
- SEM
  - Arthroplasty (Total hip) = 0.59 s <sup>(94)</sup>
  - Alzheimer's disease <sup>(92)</sup>
    - All = 2.48 s
    - Mild to Moderate = 1.52 s
    - Moderately severe to Severe = 3.03 s
  - Parkinson's Disease = 1.75 s <sup>(92)</sup>
  - Spinal cord injury = 3.9 s <sup>(92)</sup>
  - Stroke (chronic) = 1.14 s <sup>(92)</sup>

**NOTE:** The Timed Up and Go test has limited ability to predict falls in community dwelling elderly and should not be used in isolation to identify individuals at high risk of falls in this setting

### ***Tinetti Performance Oriented Mobility Assessment (POMA)*** <sup>(96)</sup>

- Cut-Off Scores
  - Older adults = 19
  - Older adults (frail) = 11
  - Parkinson's Disease = < 20
  - Stroke (chronic) = < 20
- MDC
  - Older adults
    - Individual assessment = 4.0 – 4.2 points
    - Group assessment = 0.7 – 0.8 points

- Stroke = 6 points

### **Upper Extremity Functional Index/Scale (UEFI/UEFS) <sup>(97)</sup>**

- MCID
  - UEFI-20 = 8 (95% CI)
  - UEFI-15 = 6.7 (95% CI)
- MDC<sub>90</sub>
  - UEFI-20 = 9.4 (95% CI)
  - UEFI-15 = 8.8 (95% CI)
  - UEFS = 9.8 (95% CI)

**NOTE:** UEFI-20 is a 20-item Upper Extremity Functional Index (0-80, higher scores indicate better function). UEFI-15 is a 15-item Upper Extremity Functional Index (0-100, higher scores indicate better function). UEFS is an Upper Extremity Functional Scale (8-80, lower scores indicate better function).

### **Visual Analog Scale (VAS) Scores**

- MCID
  - Hand surgery (post-operative) = 1.6 – 1.9 <sup>(98)</sup>
- MDC
  - Vestibular Disorders (Head Movement) = 4.57 <sup>(99)</sup>
- Minimum of a 2-point change on a 0-10 pain scale
- SEM
  - Vestibular Disorders (Head Movement) = 1.65 <sup>(99)</sup>

### **Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)**

- MCID
  - Arthroplasty (total knee, post) <sup>(100)</sup>
    - Function = 9
    - Pain = 11
    - Stiffness = 8
    - Total score = 10
  - Osteoarthritis
    - Hip or knee = 12% change from baseline
    - Hip (total replacement) <sup>(101)</sup>

- Pain = 29.26
  - Stiffness = 25.91
  - Knee <sup>(101)</sup>
    - 2 months = 4 – 8.8
    - 6 months = 6.6 – 6.8
    - 12 months = 1.6 – 12.0
  - Knee (total replacement) <sup>(101)</sup>
    - 6 months = 11.5
    - 12 months = 11.5
  - Lower extremity = 17 - 22% change from baseline
- MDC <sup>(101)</sup>
  - Knee (total replacement)
    - 6 months = 10.9 (95% CI)
    - 12 months = 15.3 (95% CI)
  - Hip (total replacement)
    - Function = 11.93
    - Pain = 21.38
    - Stiffness = 27.98
  - Osteoarthritis
    - Hip = 9.1 points (95% CI)
    - Hip and Knee pain = 3.94 (90% CI)
    - Knee
      - 2 months = 14.1 (95% CI)
      - 6 months = 15.0 (95% CI)
      - 12 months = 18.5 (95% CI)
- MIC
  - Arthroplasty (total knee, post) <sup>(100)</sup>
    - Function = 16
    - Pain = 21
    - Stiffness = 13
    - Total score = 17
- SEM
  - Hip (total replacement) <sup>(101)</sup>

- Pain subscale (6 months post) = 7.71
- Physical function (6 months post) = 4.30
- Stiffness subscale (6 months post) = 10.10
- Knee (total replacement) <sup>(101)</sup>
  - 6 months = 3.9
  - 12 months = 5.5
  - Pain subscale (6 months post) = 8.08
  - Physical function (6 months post) = 4.73
  - Stiffness subscale (6 months post) = 10.50
- Osteoarthritis <sup>(101)</sup>
  - Hip = 3.3
  - Knee
    - 2 months = 5.1
    - 6 months = 5.4
    - 12 months = 6.7
- Osteoarthritis (Older individuals with hip or knee)
  - Pain = 0.58
  - Physical function = 1.65
  - Stiffness = 0.62

## CODING AND STANDARDS

### Applicable Lines of Business

☒	CHIP (Children’s Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☒	Medicare Advantage

## BACKGROUND

The records must compare baseline measures to updated measures and document progress toward measurable goals as defined in Clinical Guideline and Plan of Care.

It is the responsibility of the treating practitioner to maintain a patient record that includes periodic measures of treatment response by employing valid, reliable, and relevant outcome assessment tools and include sufficient clinical documentation, so that a peer reviewer can render a reasonable determination on baseline functional status and/or treatment response.

Most individuals can expect to notice measurable improvement in pain and/or disability within 2 to 6 weeks after beginning treatment. If improvement has not occurred with 6 weeks of treatment, it is highly unlikely that continuing treatment will be helpful. When initial improvement did occur, studies showed no additional lasting improvement beyond 6 to 12 weeks of treatment. Most flare-ups resolve quickly, within a few days to 3 weeks.

When progress towards goals is such that outcome measures approximate normative data for asymptomatic populations or are indicative of mild deficits, which can typically be managed through home exercise or other self-care, then a determination of maximum therapeutic benefit (MTB) is appropriate.

## Definitions

### Episode of Care

Consultation or treatment preceded and followed by at least 3 months without treatment for the same complaint.

### Lasting, Sustainable Progress

Progress made by the patient has been maintained at a reasonable level over a reasonable period of time.

### Maximum Therapeutic Benefit (MTB)

MTB is determined following a sufficient course of care where demonstrable improvement would be expected in a patient's health status and one or more of the following are present:

- The patient has returned to pre-clinical/pre-onset health status
- Meaningful improvement has occurred; however, there is no basis for further meaningful improvement
- Meaningful improvement has occurred and there is no basis for further in-office treatment
- The patient no longer demonstrates meaningful clinical improvement, as measured by standardized outcome assessment tools
- Meaningful improvement, as measured by standardized outcome assessment tools, has not been achieved
- There is insufficient information documented in the submitted patient record to reliably validate the response to treatment

**Minimally Clinically Important Change (MCIC)**

The smallest change in the outcome assessment score that the patient perceives as beneficial, i.e., clinically meaningful improvement.

**Minimal Clinically Important Difference (MCID)**

MCID is the smallest change in an outcome that a patient would identify as important.

**Minimal Detectable Change (MDC)**

The minimal detectable change is the smallest change in score than can be detected beyond random error and is dependent upon sample distribution.

**Minimal Important Change (MIC)**

A threshold for a minimal within-person change over time, above which patients perceive themselves as importantly changed

**Outcome Measures**

- Objective, measurable assessments by the clinician to determine patient progress with treatment
- Standardized tests and measures at the onset of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning
- Used with other standardized tests and measures throughout the episode of care as part of periodic reexamination to provide information about whether predicted outcomes are being realized
- Refers to the systematic collection (data gathered at multiple time points using same methods) and analysis of information that is used to evaluate the efficacy of an intervention

**Patient Acceptable Symptom State (PASS)**

PASS is defined as the point at which the patient considers themselves well, recovered, and satisfied with treatment.

**Smallest Detectable Change (SDC)**

A value for the minimum change that needs to be observed to know that the observed change is real and not potentially a product of measurement error.

**Smallest Real Change (SRC)**

Meaningful improvement can occur only when there is a potential for MCIC. The timelines for improvement may not be applicable to some types of post-surgical care.

**Specific, Measurable, and Functional Goals**

Clearly defined goals of treatment that allow measurement of the amount and/or degree of meaningful change over time. These goals are often determined by the use of functional outcome assessment tools, as defined in Clinical Guideline, Record Keeping and Documentation Standards.

**Standard Error of Measurement (SEM)**

Estimates the standard error in a set of repeated scores.

## Treatment Goals

Determined at the initial encounter for each episode of care between the patient and clinician. Unique for each patient's clinical presentation based on the evaluation/examination findings, outcome assessment tool results, and personal preferences.

## SUMMARY OF EVIDENCE

### Clinical Practice Guideline for Physical Therapy Assessment and Treatment in Patients With Nonspecific Neck Pain <sup>(1)</sup>

- **Minimal Clinically Important Difference (MCID):** This is the smallest change in a treatment outcome that a patient would identify as important. The document mentions that both the numeric pain rating scale and the Patient-Specific Functional Scale have an MCID of 2 points.
- **Minimal Detectable Change (MDC):** This refers to the smallest amount of change that can be detected by a measure that is not due to measurement error. The document does not explicitly mention MDC, but it emphasizes the importance of using reliable and valid measurement instruments to quantify pain and functional limitations.
- **Minimal Important Change (MIC):** This is similar to MCID and refers to the smallest change in a score that is considered important by patients. The document highlights the use of the numeric pain rating scale and the Patient-Specific Functional Scale to monitor a patient's status throughout the course of treatment.

### A Core Set of Outcome Measures for Adults With Neurologic Conditions Undergoing Rehabilitation: A CLINICAL PRACTICE GUIDELINE <sup>(2)</sup>

- **Minimal Clinically Important Difference (MCID):**
  - MCID is used to determine the smallest change in a treatment outcome that a patient would identify as important. It helps in assessing the effectiveness of an intervention.
  - For example, in the context of the Berg Balance Scale (BBS), the MCID for individuals with multiple sclerosis (MS) was reported as -0.60 (clinician anchor) and -1.41 (patient anchor).
- **Minimal Detectable Change (MDC):**
  - MDC refers to the smallest amount of change that can be detected by a measure that is not due to measurement error. It is crucial for determining the reliability of an OM.
  - The document provides several examples of MDC values for different OMs:
    - For the BBS, the MDC for individuals with chronic stroke was reported as 4.66 to 6.7 points.
    - For the 10 meter Walk Test (10mWT), the MDC for individuals with chronic stable conditions was 0.18 m/s, and for chronic progressive conditions, it varied from 0.20 m/s to 0.46 m/s depending on the stage of Huntington's disease (HD).

- **Minimal Important Change (MIC):**
  - MIC is the smallest change in an OM that is perceived as beneficial by the patient. It is similar to MCID but focuses more on the patient's perspective.
  - For the 6 Minute Walk Test (6MWT), the MIC for individuals with MS was reported as 21.56 meters (whole group) and varied depending on the severity of the condition.

## ANALYSIS OF EVIDENCE

Bier et al. provides a clinical practice guideline for the assessment and treatment of patients with nonspecific neck pain. <sup>(1)</sup> The key points include:

- **Treatment Profiles:** The guideline categorizes patients into different treatment profiles based on the severity and course of their neck pain (e.g., normal recovery, delayed recovery, psychosocial factors).
- **Interventions:** The guideline recommends various interventions such as mobilization, manipulation, and exercise therapy for different treatment profiles. It advises against the use of dry needling, low-level laser, electrotherapy, ultrasound, and traction for patients with neck pain grades I, II, and III.
- **Outcome Measures:** The guideline recommends using the numeric pain rating scale and the Patient-Specific Functional Scale to quantify a patient's baseline status and monitor progress. It also emphasizes the importance of identifying and addressing prognostic factors that may influence recovery.

Moore et al. focuses on a core set of outcome measures for adults with neurologic conditions undergoing rehabilitation. <sup>(2)</sup> The key points include:

- **Outcome Measures (OMs):** The article emphasizes the importance of using OMs to monitor changes in a patient's status over time, quantify observations, and enhance communication. The core set of OMs includes the Berg Balance Scale (BBS), Functional Gait Assessment (FGA), Activities-specific Balance Confidence (ABC) Scale, 10 meter Walk Test (10mWT), 6-Minute Walk Test (6MWT), and 5 Times Sit-to-Stand (5TSTS).
- **Evidence for OMs:** The article provides strong evidence supporting the use of these OMs, including their reliability, internal consistency, and data to assist in measuring changes such as MDC and MIC. For example, the BBS has an MDC of 6.7 points in chronic stroke patients, and the 10mWT has an MDC of 0.18 m/s in chronic stroke patients.
- **Implementation:** The article emphasizes the need for standardized administration procedures and the importance of discussing OM results with patients to inform the plan of care.

### Comparative Analysis

- **Shared Conclusions:** Both articles emphasize the importance of using standardized OMs to monitor patient progress and inform treatment plans. They also highlight the need for reliable and valid measures to assess changes in patient status over time.
- **Differing Conclusions:** The Moore et al article provides a detailed analysis of specific

OMs and their psychometric properties, including MDC and MIC values, while the Bier et al article focuses more on treatment guidelines and the categorization of patients based on their recovery profiles. The Bier et al article does not provide specific MDC or MIC values for the recommended outcome measures.

- **Evidence for Measurable Progressive Improvement:** The Moore et al article provides strong evidence for the use of specific OMs and their ability to measure progressive improvement through MDC and MIC values. In contrast, the Bier et al article emphasizes the importance of identifying prognostic factors and tailoring interventions accordingly but does not provide specific evidence for measurable progressive improvement.

## POLICY HISTORY

Date	Summary
December 2025	<ul style="list-style-type: none"> <li>● Updated indications for Activity-Specific Balance Confidence Scale, Functional Rating Index, Neck Disability Index, Numeric Pain Rating Scale, Oswestry Disability Index, Pediatric Evaluation of Disability Inventory, and Timed Up and Go</li> <li>● Updated references</li> <li>● Added a Summary of Evidence and Analysis of Evidence</li> </ul>
November 2024	<ul style="list-style-type: none"> <li>● This guideline replaces Evolent_CG_605 for Measurable Progressive Improvement</li> <li>● Removed the CPT Codes section from Coding</li> <li>● Updated numerical indications based upon clinical literature, where appropriate</li> <li>● Added Knee Injury and Osteoarthritis Outcome Score for Children (KOOS-Child) as a new section in the Indications</li> <li>● Editorial changes to match the formatting and layout of the Evolent template</li> <li>● Removed duplicate/unnecessary references for concision</li> </ul>

## LEGAL AND COMPLIANCE

### Guideline Approval

#### *Committee*

**Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee**



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