Cohere Medical Policy - Physical and Occupational Therapy (PT/OT)

Clinical Policy for Medical Necessity Review

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Important Notices

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Policy Information:

Specialty Area: Musculoskeletal Care
Policy Name: Cohere Medical Policy - Physical and Occupational Therapy (PT/OT)
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Physical and Occupational Therapy (PT/OT)

Cohere Health takes an evidence-based approach to reviewing therapy procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. For initial requests, documentation must include:

- A medical history, including relevant clinical background and events leading to initiation of therapy
- Severity of the patient's functional impairment based on objective measures or patient-reported outcome measures (PROMs)
- Objective physical measures related to onset or change in symptoms
- Relevant functional outcome measure(s)
- A plan of care with therapeutic goals

For subsequent requests beyond the initial request, the following additional information is required:

- The patient's response to skilled care and treatment
- The patient's progress toward established goals or revision/addition of goals
- Clinical rationale supporting the need for continued skilled therapy

When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.

Description

Broadly, physical therapy is the diagnosis and management of movement deficits or disorders through examination, evaluation, referral, consultation, and intervention. This can include restoring, maintaining, or promoting bodily function and purposeful action appropriate to the patient's age and development.[1,2] Physical therapy (PT) treatment consists of a prescribed program to relieve symptoms, improve function, and prevent decline or disability. Procedural interventions are selected based on the needs and goals of the individual, and the clinical reasoning and decision-making of the physical therapist or the clinical problem-solving of the physical therapist assistant under the direction and supervision of a physical therapist. Physical therapy includes education and a biopsychosocial approach to care utilizing a broad range of modalities, procedures, and digital interventions. Throughout therapy, progress toward treatment goals is monitored through data collection and reassessment, and treatment strategies are adjusted as needed.

Occupational therapy involves evaluation, diagnosis, treatment planning, and interventions to support developing, recovering, or maintaining the skills required for age-appropriate self-care, work, education, and community participation.[3] Occupational therapy interventions include task-specific training, education, environmental modifications, and adaptive technologies. Throughout therapy, progress toward treatment goals is monitored through data collection and reassessment, and treatment strategies are adjusted as needed.

Treatment requires the judgment, knowledge, and skills of a licensed and certified physical or occupational therapist and cannot be reasonably learned and implemented by non-professional or lay caregivers. When delivered by a PT assistant (PTA) or OT assistant (OTA), care must be under the plan of care of a therapist with appropriate oversight as defined by the local jurisdiction. Treatment must meet generally accepted standards of practice and be targeted and effective in addressing the patient's diagnosed impairment or condition. Treatment is expected to produce clinically significant and/or presenting condition measurable improvement in the patient's level of functioning within a reasonable and medically predictable period of time; alternatively, the treatment is part of a medically necessary program intended to prevent significant functional decline. In such cases,

documentation is expected to demonstrate that the patient will experience significant regression in the absence of skilled intervention.

Medical Necessity Criteria

Indications

Physical therapy (PT) and occupational therapy (OT) are considered appropriate if **ALL** of the following are **TRUE**:

- Therapy services are provided or supervised by a qualified physical or occupational therapist[4-8]; **AND**
- **ANY** of the following:
  - The therapy occurs in an outpatient setting; **OR**
  - The therapy occurs in an inpatient setting with **ALL** of the following:
    - Treatment is required from a multidisciplinary team including **AT LEAST TWO** of the following[9-11]:
      - Physical therapy; **OR**
      - Occupational therapy; **OR**
      - Speech therapy; **AND**
    - **ANY** of the following:
      - Amputation[12,13]; **OR**
      - Major multiple trauma[14]; **OR**
      - Severe burn injury[15]; **OR**
      - Stroke[16]; **OR**
      - Spinal cord injury[17,18]; **AND**
    - Documentation in the medical record includes **ALL** of the following[19]:
      - Clinical rationale for rehabilitation in an inpatient facility; **AND**
      - Medical history relevant to this inpatient stay, rehabilitation potential, prior level of function; **AND**
      - Plan of care must include current functional status with specific and measurable goals, and progress toward those goals; **AND**
- The plan of care demonstrates medical necessity as indicated by **ALL** of the following[19-21]:
  - Documentation of functional or physical impairment, including **ANY** of the following:
    - Relevant objective measures of impairment severity or extent of deficit[B,8,22-24]; **OR**
    - Patient-reported outcome measures (PROMs)[C,22-24]; **AND**
  - Objective measures used to quantify progress or support continued treatment[8,22-24]; **AND**

- Long- and short-term goals of treatment that are specific and quantifiable (measurable)[8,22-24]; **AND**
- The amount, frequency, and duration of treatments are appropriate for the patient and diagnosis[8,25,26]; **AND**
- **ANY** of the following:
  - Reasonable expectation of recovery or improvement in function to support onset or continuation of treatment; **OR**
  - For re-evaluation: the patient is already receiving therapy and **ALL** of the following:
    - The patient develops a new condition or unanticipated significant change in functional status; **AND**
    - Documented justification that the patient requires additional evaluation; **AND**
    - Documentation of any changes to the interventions; **OR**
  - The patient requires skilled maintenance care with **ALL** of the following[27]:
    - Documentation that the patient requires skilled care[A] due to **ANY** of the following:
      - Maintenance of function is not possible without skilled care; **OR**
      - The skilled intervention is expected to prevent or delay further deterioration; **OR**
      - The patient is at imminent risk of an adverse event in the absence of a specific skilled intervention; **AND**
    - The plan of care, including number and frequency of visits, is consistent with the patient's condition and prognosis.

Removal of devitalized tissue from wounds or non-selective debridement is considered appropriate if **ALL** of the following are **TRUE**[28]:

- Documentation that medically skilled debridement is required including the type of technique used (e.g., wet-to-moist, enzymatic, abrasion); **AND**
- Documentation of objective wound assessment including drainage, color, texture, temperature, vascularity, condition of surrounding tissue, and size of area requiring debridement.

Other unlisted PT/OT service (CPT 97139) is considered appropriate when **ALL** of the following are **TRUE**:

- The service being requested does not have a specific CPT code; **AND**
- There is clear documentation demonstrating medical necessity.

Non-Indications

Physical therapy (PT) and occupational therapy (OT) are not considered appropriate if **ANY** of the following is **TRUE**:

- Continuation of care for a patient not showing progress toward treatment goals without explanation, justification, or support for continued treatment; **OR**
- Unattended electrical stimulation when used for peripheral neuropathy; **OR**
- Work hardening and conditioning; **OR**
- Dry needling; **OR**
- Any service that does not require the skills of a licensed physical or occupational therapist[A] (the establishment of a home or self-management program, and the training of the patient, patient's family, or other persons to carry it out is reimbursed as part of a regular treatment visit, not as a separate service); **OR**
- Low-level laser therapy (e.g., nonthermal and non-ablative) for post-operative pain reduction; **OR**
- Extracorporeal shock wave therapy (ESWT); **OR**
- The physical or functional deficit is reasonably expected to improve without therapy; **OR**
- Therapy that duplicates services that are provided concurrently by any other type of therapy. Each discipline should identify unique goals and intent of intervention; **OR**
- Therapy for which there is no clinical documentation or plan of care to support the need for therapy services and/or continuing therapy; **OR**
- Use of more than one hydrotherapy modality in a single day; **OR**
- Hydrotherapy with no specific therapeutic purpose; **OR**
- The service being ordered is unclear and lacks appropriate documentation (e.g., unlisted code submitted without description of service requested).

Definitions

[A]**Skilled care:** Care requiring the specific expertise, technical skills, or clinical judgement of a licensed physical or occupational therapist. The therapy, intervention, or treatment cannot be safely or effectively performed by the patient, a caregiver, or any other personnel (including a nurse, teacher, or other professional). Skilled care includes the supervision, clinical oversight, and management of physical therapy assistants, occupational therapy assistants, aides, or other support personnel and must be provided by a fully licensed therapist. Skilled care may be required due to the inherent complexity of an intervention or the patient's medical, physical, or functional condition.

[B]**Objective measures:** Reproducible, quantifiable physical assessments to assess physical or functional impairments or deficits. Examples include, but are not limited to, range of motion (ROM), muscle strength, functional tests (e.g., sit-to-stand), and balance tests (e.g., single-leg stance test).

[C]**Patient-reported outcome measures (PROMs):** Standardized questionnaires that assess the patient's experience of pain, function, activity limitations, and overall health and well-being. Examples include, but are not limited to the Victoria Institute of Sport Assessment - Achilles (VISA-A) and the international hip outcome tool- 12 (iHOT-12).

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of modality to one or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes

97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97037	Application of a modality to 1 or more areas; low-level laser therapy (i.e., nonthermal and non-ablative) for post-operative pain reduction
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory

	strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity,

	requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient

	and/or family.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several

	treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.

97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Medical Evidence

Proud et al. (2024) systematically reviewed exercises to improve hand dexterity in patients with Parkinson's disease (PD). The review included 18 randomized control trials (RCTs) with 704 patients. Activities included dexterity exercises, functional task training, and constraint-induced movement therapy. Patient dexterity was evaluated using a number of assessments (e.g., 9-Hole Peg Test, Purdue Pegboard Test, Box and Block Test, Jebsen-Taylor Hand Function Test, Coin Rotation Task, Action Research Arm Test, and Soda Pop Test). Hand function was self-reported (e.g., Manual Ability Measure, Dexterity Questionnaire, and Duruoz Hand Index). Tablet-based or customized paper/pen tests measured the speed and amplitude of patient handwriting. Moderate-quality evidence demonstrated a small positive effect on within-hand dexterity (SMD=0.26; 95% CI 0.07, 0.44), supporting the use of physical therapy (PT), including hand-specific exercises, for patients with PD.[29]

Peng et al. (2022) conducted a 3-month, single-blind RCT to determine the long-term outcomes of therapeutic aquatic exercise for patients with low back pain. Each patient was randomized to a group - the aquatic exercise group (n = 56) received aquatic therapy alone, while the PT group (n = 57) received therapy with transcutaneous electrical nerve stimulation and infrared ray thermal therapy. Sessions were conducted for 60 minutes twice a week during the 3-month trial; follow-up was 12 months (n = 98). The aquatic exercise group demonstrated "greater alleviation of disability" - adjusted mean group differences were -1.77 following therapeutic aquatic exercise, -2.42 at the 6-month follow-up, and -3.61 at the 12-month follow-up.[30]

Forsythe et al. (2021) performed a systematic review and network meta-analysis on interventions for treating adhesive capsulitis. A total of 66 studies (4042 shoulders) were included. Cohorts were organized by treatment type, including physical therapy (PT), pain injection, and arthroscopic surgical capsular release. The authors found that PT with medical or ultrasound therapy demonstrated a high level of efficacy for pain relief. PT was also effective in improving functional status and range of motion. Overall, the results showed that manipulation under anesthesia (MUA), surgical procedures, and injections without PT were all effective, with high patient outcomes across intervention type.[31]

In an update from the Department of Defense and Department of Veterans Affairs, Webster et al. (2019) outlined recommendations for rehabilitation after lower limb amputation, including a recommendation that postsurgical treatment take place in an acute inpatient rehabilitation facility. The authors note that amputation patients who receive care in inpatient care facilities have improved quality of life, mobility, ambulation, and increased use of prostheses.[12]

The American Physical Therapy Association (APTA) has developed several clinical practice guidelines addressing the prevention, management, and rehabilitation of injuries, pain, and physical deficits that limit movement and adversely impact daily living. These guidelines recommend the use of both patient-reported outcome measures (PROMs) and objective measures of pain, function, mobility, strength, and response to treatment. Generally, selection of the most appropriate functional measure(s) is guided by the clinician's judgement and the patient's specific needs, with the guidelines typically recommending that measures be taken at baseline to assess pre-treatment functioning, and again at one or more other timepoints to assess response to treatment. The guidelines also recommend therapeutic activities and exercises to address the patient's specific deficits and limitations.

- The 2023 revision of the clinical guideline on hip pain and movement dysfunction associated with nonarthritic hip joint pain contains recommendations for diagnosis, examination, and interventions.[24] Recommended PROMs include the international hip outcome tool (iHOT), the Copenhagen hip and groin outcome score (HAGOS), the hip outcome score - activities of daily living (HOS-ADL), and the hip outcome score - sports-related activities subscale (HOS-SRA). Recommended objective measures include range of motion (ROM) and strength for hip internal and external rotation, flexion, extension, abduction, and adduction. Specific recommended measures of function and postural control, include the single leg stance test (SLST), star excursion balance test (SEBT), hop distance, single-leg sit to stand, and timed measures of function.
- The 2023 revision of the clinical guideline on heel pain - plantar fasciitis recommends the foot and ankle ability measure (FAAM), foot health status questionnaire (FHSQ), foot function index (FFI), and the lower extremity functional scale (LEFS), along with measures of pain, and active and

passive ankle dorsiflexion ROM.[32] Treatment may include joint and soft tissue mobilization, plantar fascia-specific and gastrocnemius/soleus stretching, antipronation taping, and night splints.

- The 2024 midportion achilles tendinopathy revision of the clinical guideline on achilles pain, stiffness, and muscle power deficits recommends the hop and heel-raise endurance test as well as a core outcome set for achilles tendinopathy which includes the Victoria Institute of Sport assessment - achilles questionnaire (VISA-A), the single-leg heel rise endurance test, and the movement-evoked pain with tendon loading activities. Recommended interventions include tendon loading exercises, ankle plantar flexor stretching, neuromuscular exercises, and manual therapy to address identified physical deficits.[33]
- The 2024 clinical guideline on distal radius fracture rehabilitation recommends joint-specific self-report measures of the patient's pain experience and functional disability.[8] Specific recommended tests include the disability of the arm, shoulder, and hand, and the Michigan hand questionnaire. Specific recommended objective measures include wrist and forearm range of motion assessments, and grip assessments (if not contraindicated). Recommended interventions include active range of motion exercises, progressive strengthening, manual therapy, therapeutic exercises, and graded motor imagery. The guidelines also note that physical or occupational therapists should be the primary instructors of independent home exercise programs.
- The 2025 clinical practice guideline on rotator cuff tendinopathy diagnosis, nonsurgical medical care, and rehabilitation contains recommendations for managing rotator cuff pathologies including tendinopathy both with and without calcifications, and full- and partial- thickness tears.[23] The guidelines recommended use of an inclinometer or goniometer to obtain objective passive and active ROM measurements, use of a hand-held dynamometer to obtain objective measurements of isometric muscle strength of the shoulder complex, and use of validated, reliable, and responsive PROMs to measure the patient's experience of pain and disability. Specific tests to confirm or rule out rotator cuff tendinopathy include the painful arc and Hawkins-Kennedy tests.
- The 2023 clinical practice guideline on physical therapist management of glenohumeral joint osteoarthritis recommends use of a sling and progressive exercises for ROM and strengthening.[2]

- The 2021 clinical practice guideline on physical therapy management of older adults with hip fracture recommends measuring knee extension and strength, patient-rated pain, gait speed test in patients that can walk without human assistance, the timed up-and-go (TUG) test to measure mobility and fall risk, the cumulated ambulation score (CAS) to measure basic mobility and independence, and the use of academy of geriatric physical therapy guidelines to assess fall risk.[10] Specific recomendations for interventions include use of progressive high intensity resistive strength, balance, weight-bearing, and functional mobility training in the immediate post-fracture period and beyond. Additional therapies may take the form of a home-exercise program, outpatient care, or community exercise programs, notably those recommended by the US Centers for Disease Control and Prevention and the National Council on Aging.
- The 2021 revision of the clinical practice guideline on interventions for the management of acute and chronic low back pain recommends trunk coordination, strengthening, and endurance exercises to reduce low back pain and disability, treatment to promote centralization, repeated exercises in a specific direction determined by treatment response, trunk muscle strengthening, endurance, multimodal exercise interventions, specific trunk muscle activation, as well as aerobic, aquatic, and general exercise.[34] The guidelines also recommended that patients with chronic low back pain and movement control impairments be treated with specific trunk muscle activation and movement control exercise. Specific manual therapies recommended included thrust and nonthrust joint mobilization procedures to improve mobility and reduce pain and disability.
- The 2022 clinical practice guideline on exercise-based knee and anterior cruciate ligament injury prevention provided several age, sex, and sport-specific recommendations to prevent injury, particularly in youth and female athletes.[35]

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Policy Revision History/Information

Original Date: November 20, 2020		
Review History		
Version 2	06/30/2023	Policy criteria reviewed and updated per medical literature.
Version 3	12/29/2023	Policy criteria reviewed and updated per medical literature.
Version 4	09/19/2024	Policy criteria reviewed and updated per medical literature.
Version 5	10/16/2025	Annual review. Added description. Modified indications for clarity and usability. Major changes included: removal of distinct requirements for initial visit, simplification of requirements for continued care and re-evaluation, addition of criteria for maintenance care, addition of specific documentation criteria in the plan of care, addition of wound care criteria, addition of criteria for unlisted PT/OT service (CPT 97139), non-indications for dry needling, hydrotherapy with no specific purpose. Added definitions for skilled care, objective measures, PROMs. New CPT Codes: 20560, 20561, 97602 Expanded medical evidence - 9 guidelines from the American Physical Therapy Association.