National Imaging Associates, Inc.	
Clinical Guidelines **ACTIVE PROCEDURES IN PHYSICAL MEDICINE**	**Original Date: November 2015**
Physical Medicine – Clinical Decision Making	**Last Revised Date: December ~~September~~ 2023~~2~~**
Guideline Number: NIA_CG_608	**Implementation Date: July 2024~~3~~**

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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.

~~Policy~~ Statement

Evidence shows a~~A~~ctive care services ~~have sufficient~~provides ~~evidence to~~ support ~~superior~~ outcomes when used alone or in combination with manual-based treatments, and/or passive care services [1, 2]~~ (Searle, et al. 2015)~~.

Purpose

This~~ese~~ guideline~~s~~ will assist the ~~evidence based~~ physical medicine provider to ~~properly~~ accurately choose the ~~correct~~ appropriate~~right~~ service(s) when indicated for ~~proper overall~~ case management.

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

Scope

This ~~policy~~ guideline ~~will apply~~applies to all physical medicine participating network practitioners‡ who provide active procedures, data/claims processing, and peer review~~er~~s. ~~Physical medicine practitioners include chiropractors, physical therapists, occupational therapists, and speech language pathologists.~~

Clinical Reasoning

~~The current valid literature indicates the necessity of incorporating active care measures into treatment programs.~~ Interventions chosen to treat the patient's symptoms/~~ or~~ conditions should be ~~selected~~ based on the most effective and efficient means of achieving the patient's functional goals [3].

Management of Care ~~Timing of Introduction~~

Introduction and management of active care procedures should begin as soon as clinically possible and when the patient ~~the patient has~~exhibits sufficient range of motion/functional ability. Beneficial and effective active care services should generally be provided within the first two weeks of intervention [4].

~~Acute care cases~~

- ~~The literature supports the introduction and management of active care procedures as soon as clinically possible once the patient has sufficient range of motion/functional ability. For the care to be considered beneficial and effective, active care services should generally be provided within the first two weeks of intervention. For the purpose of these guidelines, aAAn acute care case is when a patient is seen for treatment within 7 seven days of the onset of the illness, injury, and/or medical intervention [4].~~

~~Subacute care cases~~

- ~~Similar to acute care cases, the literature supports the introduction and management of active care procedures as soon as clinically possible once the patient has sufficient range of motion/functional ability. For the care to be considered beneficial and effective, active care services should generally be provided within the first two weeks of intervention. For the purpose of these guidelines, aA subacute care case is when a patient is seen for treatment between 7 and 21 days after the onset of an illness, injury, and/or medical intervention [4].~~

~~Chronic care cases~~

- ~~The literature supports the introduction and management of active care procedures at the onset of intervention, either the first or second visit. For the purpose of these guidelines, aA chronic care case is when a patient is seen for treatment beyond 21 days after the onset of an illness, injury, and/or medical intervention, or. Chronic conditions that have intermittent episodes will also be considered chronic in nature for the purpose of these guidelines [4].~~

Documentation Requirements

Medical Necessity

Written documentation ~~(entire record)~~ should indicate services~~they~~ meet the requirements for medical necessity and should include the following [5]:

- Services are skilled
- ~~Services are rehabilitative~~
- Skilled services are required **AND** provided by skilled clinicians‡ (or qualified professionals when appropriate with approval of a physician/NPP)

- Skilled clinicians must have the expertise, knowledge, clinical judgment, and decision-making abilities that otherwise caretakers and patients do not have independently
- Skilled clinicians must apply their skills and actively participate in the treatment of the patient during each progress report period and document skilled treatment provided or modification to skilled treatment

~~Services are required by the patient (factors contributing to need vary but often are related to the following)~~

- ~~Patient's diagnosis (including complicating factors)~~
- ~~Age~~
- ~~Severity~~
- ~~Time since onset/acuity~~
- ~~Self-efficacy~~
- ~~Cognitive ability~~
- ~~Prognosis~~
- ~~Medical, social, psychological stability~~

- Services are safe and effective

Therapy Services

- Evaluation and Plan of Care (by skilled clinician) must include: [5]
  - Initial and re-evaluations
    - Necessity for course of therapy through objective findings and subjective patient self-reporting
    - Patient-specific need for care and intervention (activities of daily living [ADL], mobility, and safety)
    - Timeline for initiating, progressing, and discharging patient from skilled services
    - Specific treatment parameters to support the intervention (appropriate service type, frequency, intensity, and duration for individual need of the patient)
    - Measurable goals that support the identified intervention with identified precautions
- Progress Reports or daily treatment notes should include [5]:
  - 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

- 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)
    - Specify evidence that skilled services of a physical medicine provider/practitioner‡ are needed (beyond establishment of the program)
    - Specify evidence that interventions are parte of a comprehensive rehab program with the goal of improving the functional status
    - Plan of care guided by functional impairments (not the intervention itself)

~~**Documentation must support the medical necessity for the services requested and why the skills of a licensed professional are needed to render the service. The provider must outline the patient-specific rationale/need for care and intervention as it relates to the patient's condition and resultant functional limitations in activities of daily living, as well as mobility and safety, as identified in a comprehensive evaluation. Based on these findings, a plan of care is developed that includes specific and measurable goals that support the need for the identified interventions.[5]**~~

~~**Documentation must include a timeframe for initiating, progressing, and discharging the patient from skilled services. Documentation must also include specific treatment parameters to support the intervention, in addition to applicable precautions. This includes the specific type of procedure, instruction and/or exercise performed, area of body and muscle groups treated, and time component.[5]**~~

Billing Units~~enial~~

This organization follows Medicare rules for reporting timed units [6].[6] Billing units are based on 15 minutes per unit for time-based codes. T~~and th~~he units listed below are the Medicare minimum time requirement for a service to be justifiably billed.

- 1 unit ≥ 8 through 22 minutes
- 2 units ≥ 23 through 37 minutes
- 3 units ≥ 38 through 52 minutes
- 4 units ≥ 53 through 67 minutes
- 5 units ≥ 68 thorough 82 minutes
- 6 units ≥ 83 through 97 minutes
- 7 units ≥ 98 through 112 minutes
- 8 units ≥ 113 through 127 minutes

NOTE: ~~Individual s~~States may have varying statutory guidelines for reporting timed units that supersede ~~this organization's requirements~~Medicare rules.

CPT Code~~s Definitions, Examples, and Requirements~~

97110 - Therapeutic Exercise

Defined

- ~~**Definition:**~~
- ~~T~~Although not exclusive by definition, therapeutic exercise is any exercise planned and performed to attain a specific goal~~. Goals would be to~~ (increase strength, endurance, range of motion, and flexibility)
- Therapeutic procedures/exercise could be applied to one or more areas and billed in units as noted above

Parameters ~~for Use:~~

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

- ~~M~~Evidence to support medical necessity ~~and supportive evidence~~
- ~~Plan of care~~
  - ~~S~~with specific and measurable goals
  - ~~and T~~timeframe for initiating, progressing, and discharging the patient from skilled medical services to an independent home program
- Detailed ~~description of~~ active care services including~~:~~:
  - Wh~~ich~~~~at~~ exercise(s) were provided
  - What body area (including~~and~~ muscle groups) the exercise(s) target~~were intended~~~~provided to~~
  - 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‡ ~~in direct contact with one patient~~

~~T~~Medical research supports ~~t~~he initiation of appropriate therapeutic procedures/exercise begins as soon as the patient is reasonably able to engage in the planned activity. ~~T~~Therefore, ~~t~~he expectation is for ~~a~~ the patient to learn~~,~~ and perform therapeutic exercises ~~and receive a~~with a detailed home exercise program within a reasonable timeframe.~~.~~ [7, 8][7 18] ~~Based on the definition and guidelines for services that are medically necessary, the expectation is for the provision of the~~

~~therapeutic procedures/exercises that are not for the convenience of the patient or health care provider or more costly than an alternative form of treatment.~~

~~Guidelines regarding t~~The use of high tech fitness equipment~~machines~~ (e.g., MedX equipment, cervical/lumbar extension machines, Isostation B-220 Lumbar Dynamometer, Cybex Back System~~, etc.~~) ~~show insufficient~~ lacks evidence of improved outcomes ~~that they are more efficacious~~ compared to~~than~~ the use of standard exercise equipment. [9] ~~or that their use improves clinical outcomes to a greater extent than standard programs (addtl ref needed)~~

~~**Examples**~~

- ~~Strengthening of select muscle groups (beginning in gravity-eliminated plane, (if needed) progressing to anti-gravity plane utilizing body weight with progressive resistive exercises (utilizing Tthera-Ttubing, exercise ball, free weights, etc.)~~
- ~~C; closed chain exercises are often preferrederable to open chain exercises in preventing shearing forces and simulating functional activities)~~
- ~~M; monitored graded exercise following cardiac or pulmonary surgery or heart attack~~
- ~~;S selective stretching to increase joint range of motion (ROM).~~

Services Support ~~**for this service**~~

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 patient is 'working out' in the clinical setting (considered not medically necessary and not eligible for reimbursement).

- L~~Indications must be documented for l~~oss or restriction of joint motion, reduced strength, and functional capacity or mobility concerns
  - ~~.~~The clinical records need to objectively validate ~~must validate show objectively~~ive (quantitative if possible) the loss of ROM, strength, flexibility, or functional mobility
  - ~~.~~The therapeutic exercise code is generally ~~**not**~~ **NOT** reimbursable for
    - Increasing a patient's endurance without deficits
    - Promotion of overall fitness
    - Weight loss
    - Return to work
    - Return to sports (~~, for~~ sports~~(s)~~/~~ and/or~~ recreation~~,~~ and/or sports/~~ and~~ aerobic conditioning)~~.~~

- ~~Documentation must include evidence of the skilled services required to support the use of therapeutic exercise. It is considered a s~~Services are required and provided by skilled clinicians‡ (or qualified professionals when appropriate with approval of a physician/NPP)
  - ~~killed service that would require proper licensure/credentials of the clinician. Without evidence in the documentation to support the need for skilled services, the records would suggest the patient is "working out" in the clinical setting, which is generally not medically necessary and not eligible for reimbursement.~~

- ~~Most programs should entail o~~Patient c~~ne to three units at any time to ensure c~~ompetency and compliance ~~with instructions~~ with instructions require ~~.~~
  - One to three billing units at a time
  - > 3 billing units needs supported clinical documentation
  - ~~The clinical rationale for more than three units would need to be clearly supported by documentation. If more than three units are being utilized per session, this might indicate the patient is "working out" in the clinical setting which is generally not considered medically necessary.~~
  - ~~will not result in further in-office instruction being considered medically necessary. The patient should instead be discharged for non-compliance/acting against medical advice.~~

- ~~One to three sessions of i~~In-office patient exercise
  - 1-3 sessions ~~should be sufficient,~~ for the non-surgical patient
    - ~~t, E~~to ~~e~~nsure competency and compliance with a home exercise program
  - >~~. If in-office repetitive exercise continues after~~ 3 sessions
    - ~~, the record must clearly d~~Document reason(s)~~why the~~ the patient is ~~not able~~unable to participate in a home exercise program
    - ~~. Any a~~Active care program may include periodic review ~~of the program~~ as part of case management in regard to monitoring continued therapeutic benefit and progression
    - C~~in specific exercises/instructions. This ongoing c~~ase management should outline
      - Patient compliance
      - ~~, necessary A~~~~a~~lterations and progression to ~~any~~ active home care program
      - ~~, progression in specific active home care program, and A~~~~a~~nticipated termination date ~~for the need~~ for skilled in-office services~~.~~

Noncompliance

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

97112 - Neuromuscular re~~-~~-education [10, 11]~~19~~

Defined~~nition:~~

- 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
  - ~~(defined as the three modalities of joint position: sense, sense of movement and sense of force). ~~Neuromuscular deficits~~Injuries~~ requiring re-education may be associated with stroke, closed head injury, spinal cord injury, tumor, congenital

disorders (~~such as~~ cerebral palsy or secondary to degenerative joint disease), musculoskeletal injury (~~such as~~ ankle sprain, post orthopedic surgery, or prolonged immobilization) [12].~~.~~

- Neuromuscular re-education may be considered medically necessary if at least ~~one~~ **ONE** of the following conditions is present ~~and~~ (documented)~~:~~
  - ~~The patient has t~~The loss of deep tendon reflexes and vibration sense accompanied by
    - Paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers~~.~~
  - ~~The patient has n~~Nerve palsy (e.g., ~~, such as~~ peroneal nerve injury causing foot drop)~~.~~
  - ~~The patient has m~~Muscular weakness or flaccidity from~~, as a result of a~~
    - C~~c~~erebral dysfunction
    - ~~, a~~ N~~n~~erve injury or disease
    - ~~, or has had a~~ S~~s~~pinal cord disease
    - ~~or~~ T~~t~~rauma~~.~~
  - ~~The patient has m~~Muscle compensations requiring targeted exercise to produce stable, coordinated movements during functional tasks [13][20]
  - ~~The patient has p~~Peripheral or central vestibular dysfunction causing dizziness, vertigo, imbalance, or disequilibrium that supports the use of Vestibular Balance and Rehabilitation Therapy (VBRT) [14, 15][21,22]

~~**Examples**~~

~~Treatment involves the stimulation of reflexes, sensation, posture, proprioception and motor activity through;~~

- ~~R~~rocker/BAPS board
- ~~, M~~mini-trampolines
- ~~, T~~targeted exercises to spastic or rigid muscles
- ~~, B~~balance training
- ~~, P~~proprioceptive neuromuscular facilitation (PNF)
- ~~, F~~eldenkrais
- ~~, B~~obath
- ~~N, n~~eurodevelopmental treatment (NDT)

~~D, and desensitization techn~~

Services **Support** ~~**for this service**~~

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

- Document~~ation must support~~ the need for individual, in direct contact skilled therapy services by a licensed professional[‡] ~~in direct contact with one patient.~~
-
- Document ~~An indication of the lesion of t~~the injury to the neuromuscular ~~o~~skeletal system ~~needs to be documented~~ and the therapeutic ~~the exact~~ procedure(s)

- Provide and document home care instructions and education~~must be noted. Instructions for home care should be seen within a reasonable timeframe and the service discontinued with proper education and instruction given to the patient.~~

97113 - Aquatic Therapy [16]~~23~~

Defin~~edition~~

- 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 ~~A therapy program utilizing therapeutic exercise techniques with the properties of water, designed and carried out in a suitably heated hydrotherapy pool by a qualified clinician specifically for an individual to improve function. Examples:~~
- Treatment 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 [17]
  - ~~,~~Aquatic PNF [18]~~,~~ ~~24~~
  - ~~the~~ Bad Ragaz Ring Method (BRRM) [19]~~,~~ ~~25,26~~
  - ~~Fluid Moves, the~~ Halliwick~~-~~ Therapy [20]~~Concept,~~ ~~27,28~~
  - ~~Swim Stroke Training and Modification~~
  - ~~,~~Task Type Training Approach and Watsu [21]
  - Aquatic Cardiovascular Training (ACT) [22]~~.~~ ~~29~~ ~~Treatment to address improved circulation and decreased venous pooling, increased endurance facilitated through the availability of cardiovascular training with less stress on weight-bearing joints or working with enhancement of balance and coordination as a result of the buoyancy obtained from an aquatic environment.~~
  -

Services Support ~~for this Service~~

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‡ ~~Documentation must support the need for skilled services by a licensed professional in direct contact with one patient.~~
- ~~The patient would need to be~~ Provided in a ~~heated~~ ~~immersed in a~~ pool of water deemed safe and appropriate for patient therapy~~for this code to apply.~~
  -

- Provide the patient'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

~~The provider must also indicate the medical necessity for the buoyancy, hydrostatic pressure, and heat properties that are present in a pool setting versus standard land-based therapeutic exercise or activities. This is often used to transition the patient to a land-based program.~~

97116 - Gait Training

Defined~~ition~~

- Training the patient ~~in specific activities that will~~to ~~facilitate~~ ambulate~~ion~~ on varied surfaces and stair climbing with or without an assistive device; t~~. T~~his includes training in rhythm, speed, sequencing, and safety ~~instructions.~~

~~**Examples**~~

~~Gait training can be useful for people with any condition needing to learn/re-learn proper ambulation to allow for functional performance and mobility; c. Common conditions requiring gait training include:~~

- ~~Aamputation~~
- ~~, Oosteoarthritis~~
- ~~M, muscular dystrophy~~
- ~~C, cerebral palsy~~
- ~~Developmental delay~~
- ~~Down syndrome~~
- ~~S, stroke~~
- ~~, Parkinson's disease~~
- ~~Me, multiple sclerosis~~
- ~~, Bbrain/spinal cord injuries~~
- ~~P, post-surgical~~
- ~~S, sports injury~~
- ~~L, and low back pain.~~

Services Support ~~for this Service~~

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

- ~~The provider should c~~Consider the contextual factors that affect ~~a person's~~the patient's ability to participate in meaningful ADLs~~.~~ [23]
- ~~-~~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

- .[30] Documentation must support the need for skilled services by a licensed professional in direct contact with one patient as opposed to just addressing endurance deficits alone, or continue to treat until the patient can move to a lesser supportive assistive device.
-
- Deficits in gait parameters including walking speed, cadence, stride length and balance, and functional ambulation category scores must be documented. The provider would need to dDocument if body-weight support (BWS) systems, unweighting devices, or assistive devices are used
- . The record mustDocumentation should includedenote the assessment of the phases of gait to include:
    - Stance phase
    - Stride length
    - Balance issues
    - A and what the ankle, knee, hip, and low back are impact doing during the phases of gait cycle.

97760 - Orthotics Management and Training

Definedition

- Orthotic(s) management and training, including aAssessment and fitting when not otherwise reported as a separate L HCPCS code (L-code)
- Fitting and training
- Upper or Lower extremity (or extremities), lower extremity or extremities, and/or trunk, each 15 minutes.

Additional InformationExplanation

- AThis code applies to custom-fabricated or adjustments to over-the-counter orthotics
- and for adjustments to over-the-counter orthotics. The oOrthotics management portion of this code refers to time spent assessing the need, for the orthotic and the type, fitting and fabrication of the orthotic (as well as the fitting and the fabrication if the 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
- .TThe training portion of this code includes training in the care and use of the orthotic device.
-
- This code cannot be used if the orthotic is fabricated/formed without the patient being present. Supplies and time for the actual 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** for this Service

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‡
- ~~The need for an o~~Orthotics ~~require~~s documented support
  - P~~. This would include a p~~roper examination (not ~~just a~~ vendor specific evaluation)
  - O~~along with the o~~utline ~~of~~ the causal nexus to justify inclusion ~~for any complaints~~(all complaints other than foot-based)~~.~~
    - Foot-based complaints need ~~a detailed~~further notation as to the fault/deficit present ~~that~~ requiringes ~~custom orthotics versus usage of a~~ heel lift or over-the-counter orthotics.
  - ~~P~~Patients~~This service~~ should typically not be seen more than once per calendar year for one set of orthotics
  - ~~.~~Orthotic use is based on plan benefit~~.~~

~~**Documentation must also support why the skills of a licensed professional are needed for the training in care and use of the orthotic.**~~

97761 - Prosthetic Training

Defined~~ition~~

- Assessment of the ~~F~~functional mobility and ~~activities of daily living (~~ADLs (Activities of Daily Living) while training and practicing with the prosthesis~~)~~
- ~~assessment, T~~training with the prosthesis~~,~~ (upper and/or lower extremity)~~.~~
  - ~~This would include i~~Instruction and practice in use of prosthesis~~.~~

Services Support ~~for this Service~~

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

- ~~The patient would need to be the recipient of a~~ New prosthetic device or ~~require~~ adjustments to current prosthetic device to improve function~~.~~

97763 - Checkout for Orthotic/Prosthetic Use - ~~,~~ Established Patient

Defined~~ition~~

- Training and management of s~~Orthotic(s)/prosthetic(s) management and/or training, upper extremity or extremities, lower extremity or extremities, and/or trunk, s~~ubsequent encounters for orthotic(s)~~(s)~~ or ~~/~~prosthetic(~~(s)~~s) for the upper/lower extremity(ies) and/or trunk ~~encounter.~~

Services Support ~~for this Service~~

- Document the need for individual skilled therapy services by a licensed professional‡ ~~Documentation must clearly support the skilled need of a licensed professional for the adjustments.~~

97530 - Therapeutic Activities

Defined~~ition~~

- D~~This code includes the use of d~~ynamic activities in teaching/ ~~and~~ training the patient to improve functional performance in a progressive manner~~.~~

~~**Examples**~~

- ~~Activities that address~~addressing ~~quantifiable~~ measurable ~~deficits (e.g., loss of ROM, strength, or functional capacity) resulting in~~which cause ~~a deficit in functional mobility~~mobility deficit ~~(~~. Functional mobility may include ~~e.g.,~~ bending, reaching, lifting, carrying, pushing, pulling, bed mobility, ~~and~~ transfers~~).~~

Services Support ~~for this Service~~

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‡
- Coverage for ~~Documentation must support the need for skilled services by a licensed professional in direct contact with one patient.~~
-
- ~~In order for t~~therapeutic activities, ~~to be covered, all~~**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 patient~~'s condition is such that he/she~~ is unable to perform therapeutic activities (due to condition) except under the direct supervision of a skilled and licensed therapy services ~~licensed~~ professional ~~physician, occupational therapist, or physical therapist~~
    - ~~There is a clear c~~Correlation between ~~the type of exercise performed and~~ the patient's underlying medical condition and the type of exercise performed f~~f~~or which the therapeutic activities were prescribed

- The therapeutic exercise code is generally **NOT** reimbursable for:
    - Increasing a patient's endurance without deficits
    - Promotion of overall fitness
    - Weight loss
    - Return to work
    - Return to sports (sports/recreation **and/or** sports/aerobic conditioning)

~~The code is generally not reimbursable for increasing a patient's endurance without deficits, promotion of overall fitness, weight loss, return to sports, and/or sports and aerobic conditioning.~~

97129 - Cognitive Skills Development

Defined~~ition~~

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

~~), direct (one-on-one) patient contact.~~

~~**Examples**~~

- ~~Individuals with iInherited learning disabilities~~
- ~~, individuals who have lost cCognitive impairment skills as a result offrom illness or brain injury~~

Services Support ~~for this Service~~

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‡
- Document c~~C~~ognitive deficits ~~would need to be present and quantifiably documented.~~(quantifiable) ~~Documentation must support the need for skilled services by a licensed professional in direct contact with one patient~~

97533 - Sensory Integration

Defined~~ition~~

- Treatment techniques ~~designed~~ to enhance sensory processing and adaptive responses to environmental demands~~.~~
- ~~I~~
- ~~The goal of sensory integration therapy is to i~~mprove ~~the way~~how the brain processes sensory information, organizes and responds appropriately ~~as a foundation~~ for ~~later, more~~ complex learning behavior~~.~~

~~Examples~~Additional Information

- Sensory integration (SI) therapy ~~- has been proposed as a~~ treatment of developmental, environmental, or acquired brain disorders in patients with established dysfunction of sensory processing which may be associated with: ~~(e.g.,~~
  - Neurodevelopmental Disorders such as ~~c~~Autism Spectrum disorder, A~~, a~~ttention deficit hyperactivity disorder (ADHD), Intellectual Disability, Conduct Disorders, and Language Communication Disorders that may be causes from:
    - Fetal alcohol syndrome
    - Genetics
    - Neurotransmitter imbalance
    - ~~). Sensory integration disorders may also be a result of i~~Illness
    - B~~ or b~~rain injury~~.~~
- ~~~~
- Therapy ~~usually~~ 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: ~~provide;~~
  - Vestibular – which could include the use of~~:~~
    - ~~Swings or trapeze bars are used to incorporate vestibular input~~
  - Proprioceptive – which could include the use of~~:~~
    - ~~Trapeze bars, large foam pillows, or mats used to stimulate somatosensory pathways of proprioception and deep touch~~
  - ~~o~~ Tactile – which could include the use of~~:~~
  - ~~Tactile reception may be addressed through activities and surface textures involving light touch~~
  - Visual
  - Auditory ~~stimuli ,~~

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 ~~for this Service~~

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‡
- Document sensory processing deficits impacting functional skills
- Sensory integration therapy ~~is usually~~ provided by occupational and physical therapists ~~.~~

~~**Documentation must support the need for skilled services by a licensed professional in direct contact with one patient.**~~

97535 - Self-care/Home Management Training

Defined~~ition~~

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

~~**Examples**~~

~~Activities that addressing quantifiable deficits resulting in functional limitations in ADLs/IADLS;, such as~~

~~t~~Toileting

~~C, continence~~

~~B, bathing~~

~~D, dressing~~

~~P, personal hygiene~~

~~H, housecleaning~~

- ~~E, eating and meal preparation.~~

Services Support ~~for this Service~~

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‡
- ~~Documentation must support the need for skilled services by a licensed professional in direct contact with one patient.~~ Document~~ation~~ the ~~should~~ related ~~the~~ ADL instruction to the patient's expected functional goals and ~~and~~ indicate ~~that~~ it is part of an active treatment plan directed at a specific goal~~.~~

97542 - ~~–~~Wheelchair Management and Training

Defined~~ition~~

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

NOTE: ~~(~~97001 and 97002 cannot be billed with this code~~).~~

Services Support ~~for this Service~~

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‡
- Document~~ation should include~~ the current ~~recent~~ event that prompted ~~the need for~~ a skilled wheelchair assessment
- Document results of prior~~any previous~~ wheelchair assessments
- Document functional level (current and previous)
- Document interventions ~~that were tried~~attempted by nursing staff, caregivers, and/or the patient to address poor seating or positioning
  - ~~F; and any functional deficits or applicable impairments related to;~~
    - ~~Range of Motion (, such as ROM)~~
    - ~~S, strength~~
    - ~~S, sitting balance~~
    - ~~S, skin integrity~~
    - ~~S, sensation~~
    - ~~T, and tone.~~
- Document~~ation~~ correlates the training provided to ~~the~~ expected functional goals ~~that are attainable~~ by the patient and/or caregiver
- Document the r~~, along with the r~~esponse of the patient to the instruction or fitting~~.~~

~~**The documentation must clearly support that the services rendered required the skills and expertise of a licensed therapist.**~~

97537 - Community Work Reintegration

NOTE: 97537 Community work reintegration is ~~—~~typically not a covered service

Defin~~ed~~ition~~

- Instructing and training the patient in community and/or work re-integration activities:
  - ~~. These activities could include s~~Shopping
  - Safely accessing transportation sources
  - Money management
  - Avocational activities ~~and~~or~~/or~~ work environment ~~/~~modification analysis [24, 25]~~,~~[31]
  - Work task analysis
  - Assistive technology devices and/or adaptive equipment use~~.~~

~~Examples~~Additional Information

- Community reintegration is ~~often~~ performed in conjunction with other therapeutic procedures such as:~~;~~
  - Gait training
  - Self-care or ~~/~~home management training
- ~~. The payment for community reintegration training~~Billing is often bundled into the payment for ~~those~~ other services~~;. Therefore, those~~ other services are not usually reimbursed separately ~~reimbursable.~~

-
- The following s~~S~~ervices on assistive technology devices and/or adaptive equipment provided to the patient by a third-party payer are not covered if the devices/equipment are not covered by the third-party payer:~~;~~
  - Issue
  - Modify
  - Adjust
  - Educate
- ~~the patient on assistive technology devices and/or adaptive equipment typically will not be covered if the adaptive equipment and/or assistive technology device(s) are not covered by the third-party payer.~~
-

  ~~Generally, s~~Services ~~which are~~ related t~~solely t~~o ~~specif~~the listed items~~ic~~ 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 [26]:~~;~~
  - Employment opportunities
  - Work skills
  - ~~o~~ Work ~~settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by Section 1862(a)(1) of the Social Security Act.~~
  -

Services Support ~~for this Service~~

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‡‡

~~Documentation would need to provide evidence to support the medical necessity and the need for skilled services provided to the patient.~~

97545 - Work Hardening/Conditioning

NOTE: 97545 Work hardening/conditioning is **typically not a covered service**

NOTE: 97545 is for ~~—~~initial 2 hours, use 97546 for each additional hour ~~and use in conjunction~~ with 97545

Defin~~ed~~ition

- ~~Work hardening includes j~~Job simulation tasks, exercises, and ~~and~~ educational activities related to a safe return to work ~~for the patient.~~
- I~~Often, work hardening programs incorporate an i~~nterdisciplinary approach to restore physical, behavioral, and/or vocational functions~~.~~
- ~~Work conditioning includes exercises directed towards safely returning the patient to work-related activities or to commence with vocational rehabilitation services. In general,~~ Work conditioning programs are designed to address neuromuscular functions, such as:
  - Flexibility
  - Strength
  - Endurance
  - Range of motion
  - Cardiopulmonary functions~~.~~

~~Examples~~Additional Information

- Work-induced injury and/or impairment ~~was present~~ that resulted in the need for therapeutic exercises/procedures~~.~~
- C~~Once the patient has c~~ompleted~~ed~~ acute medical care ~~, including~~ (chiropractic or rehabilitation treatment)~~,~~ by the~~the~~ patient may require a ~~-~~comprehensive ~~, intensive,~~ and individualized program for safely returning to work ~~activities.~~
- Patient may begin a work hardening and/or work conditioning program~~.~~
  - Patient will participate in a program for at least two hours a day, three days a week ~~to as much as~~up to eight hours a day, five days a week
  - Activities ~~performed by the patient~~ 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 ~~training, and/or~~
    - Occupational/educational training ~~aspects.~~

Services Support ~~for this Service~~

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

- Documentation~~ted~~tation ~~would need to support~~ ~~that~~ the patient had an injury and/or impairment within the last 12 months
- Documentation the patient~~ed support the patient ,~~ has received acute rehabilitation services~~,~~ and is expected to return to his/her previous employment~~.~~
- Documentation~~ation should clearly report~~ the patient's limitations regarding:~~;~~
  - Returning to work
  - ~~; the patient's w~~Willingness to participate in the program~~; a~~

- Document ~~highly structured, goal-oriented~~ plan of care (structured and goal-oriented), including discharge from skilled services and a reference to return to work
- ~~and discharge from skilled services; i~~Identifyfied 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 ~~would not be~~is not prohibited
- Identify psychosocial and/or vocation problems and evidence of a referral to the appropriate professional~~.~~

BACKGROUND

Health Care Providers

~~‡~~A qualified licensed health care provider (chiropractors, physical therapists, occupational therapists, physician assistants, speech therapists, physical therapist assistants, and occupational therapy assistants) ~~is an individual who~~ by education~~,~~ ~~,~~ training, and licensure/regulation performs a professional service within his/her scope of practice and reports to health ~~a~~ professional boards~~service~~. ~~These providers are distinct from 'clinical staff' (e.g., physical therapy aide or speech language assistant).~~

A clinical staff member ~~is a person who~~ works under the supervision of a qualified health care provider and ~~who~~ is allowed by law or regulation to perform or assist in the performance of a specified professional service (e.g., physical therapy aide or speech language assistant). ~~Examples of qualified health care providers for the purpose of this policy include chiropractors, physical therapists, occupational therapists, physician assistants, speech therapists, physical therapist assistants, and occupational therapy assistants.~~

A clinician may not merely supervise but must apply the skills of a professional by actively participating in the treatment of the patient. ~~In addition, a~~The ~~provider's~~ skills ~~may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task~~of the clinician should be clearly documented (e.g., the clinician's descriptions of their skilled treatment, changes made to the treatment due to a clinician's assessment of the patient's needs on the treatment day, changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task) [5].~~;~~

Services

Overview

The patient's medical condition is a factor in decisions about health care services, diagnosis or prognosis is not the lone basis in deciding that skilled care services are reasonable and necessary. The key judgment is if the skills of a qualified licensed health care provider are needed to treat the illness or injury or if the services can be carried out by unskilled personnel.

Skilled care services are not required to effect improvement or restoration of function when a patient suffers a transient (reversible loss) or reduction of function which could reasonably be expected to improve naturally as the patient gradually resumes normal activities. Skilled care services provided in these situations are **NOT** considered reasonable and necessary for the treatment of the individual's illness or injury.

Health care services are considered 'active' when the patient takes part in the completion of the service and 'passive' when the patient receives services without any physical input or effort.

Skilled

The services outlined in this guideline require the provision of skilled therapy services by a qualified licensed health care professional‡ and direct (one-on-one) provider-patient contact.

Skilled ~~rehabilitative care~~ services must be part of a documented treatment plan ~~provided~~ to improve or restore lost or impaired physical function resulting from illness, injury, neurologic disorder, congenital defect, or surgery. ~~These s~~Skilled care services ~~are intended to~~ enhance the rehabilitation and recovery by clarifying a patient's impairments, ~~and~~ functional limitations ~~as well as by~~and identifying interventions, treatment goals, and precautions.

~~Skilled care services are not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function, which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Skilled care services furnished in such situations are **not** considered reasonable and necessary for the treatment of the individual's illness or injury.~~

~~**Definition**~~

~~The following services are considered "active" meaning the patients themselves take part in the completion of the service. This is opposed to "passive", where the patient passively receives health care services without any physical input or effort.~~

~~All services outlined in this section require the provision of skilled services and direct (one-on-one) provider-patient contact.~~

~~While an individual's medical condition is a valid factor in making decisions about health care, the diagnosis or prognosis cannot be the sole basis in deciding that skilled care services are reasonable and necessary. The key judgment is whether the skills of a qualified health care provider are needed to treat the illness or injury or whether the services can be carried out by unskilled personnel.~~

~~Regardless of the expectation of improvement, reasonable and necessary skilled care services must be provided by a qualified health care provider and require a high level of complexity and sophistication or the condition of the patient is such that the services can be safely and effectively performed only by a qualified health care provider.~~ ***Unskilled***

Services that do not require the performance or supervision of a qualified health care provider are ~~not~~ **NOT** skilled and are ~~not~~ **NOT** considered reasonable or necessary services~~;~~, even if they are performed or supervised by a qualified licensed health care professional. ~~Therefore, if a service can be self-administered or safely and effectively furnished by an unskilled person or caregiver, without the direct or general supervision of a qualified health care provider, the service cannot be regarded as skilled even if a qualified professional actually furnishes the service. Further, the unavailability of a competent person to provide a non-skilled service, despite the importance of the service to the patient, does not make it a skilled service when a qualified health care provider furnishes the service. A clinician may not merely supervise but must apply the skills of a professional by actively participating in the treatment of the patient. In addition, a provider's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.~~

Services ~~related to~~ (activities) for the general good and welfare of patients (e.g., general exercises to promote overall fitness or ~~and~~ flexibility, ~~and~~ activities to provide ~~diversion~~ distraction or general motivation) do not constitute skilled ~~care~~ services.

~~Services provided by practitioners/staff who are not qualified health care providers are not skilled intervention services.~~ Unskilled services ~~are~~ include palliative procedures that are repetitive or reinforce previously learned skills or services performed to maintain function.

Reasonable and Necessary:

Skilled care services (reasonable and necessary) must be provided by a qualified health care provider, require a high level of complexity, or the services can only be safely and effectively performed by a qualified health care provider due to the condition of the patient.

~~The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can only be performed safely and effectively by a qualified health care provider.~~

~~-~~Rehabilitative therapy services are designed to address recovery or improvement in function or restoration to a previous level of health and well-being. Improvement is evidenced by successive

objective measurements resulting in improved functional outcomes (e.g., impairments and~~,~~ pain~~, functional status~~). If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of the therapy services required to achieve such ~~potential~~potential, then rehabilitative therapy services is **NOT** reasonable and necessary. ~~Services that do not require the performance of a qualified health care provider are not skilled and are not considered reasonable or necessary.~~

Objective Evidence

~~:~~Consists of serial standardized assessment tools~~, /~~instruments, outcome measurements, ~~and~~ or measurable assessments of functional outcome used to quantify functional progress of the patient and support justification for continued treatment. Examples of objective evidence include:

- Functional assessment from standardized and validated outcomes instruments; **OR**
- Functional assessment scores from tests and measurements that are validated in the professional literature, which are appropriate for the condition/function being measured~~.~~

In isolation, ~~physical~~ objective measures (e.g., range of motion or manual muscle strength testing) are generally not considered to be functional assessment measurements of a patient. ~~of objective evidence' of a functional assessment.~~

~~**Rehabilitative (Restorative) Services:** Services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Improvement is evidenced by successive objective measurements whenever possible (e.g., impairments, pain, functional status, etc.). If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary. Rehabilitative care must require the skills and level of sophistication of a qualified health care provider. Services that can be safely and effectively furnished by non-skilled personnel or caregivers are not rehabilitative care services.~~

~~Skilled rehabilitative care services must be part of a documented treatment plan provided to improve or restore lost or impaired physical function resulting from illness, injury, neurologic disorder, congenital defect, or surgery. These skilled care services are intended to enhance rehabilitation and recovery by clarifying a patient's impairments and functional limitations as well as by identifying interventions, treatment goals, and precautions.~~

~~**Reasonable and Necessary:** The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can only be performed safely and effectively by a qualified health care provider. Services that do not require the performance of a qualified health care provider are not skilled and are not considered reasonable or necessary.~~

POLICY HISTORY

Date	Summary
December 2023	• The following sections had the listed 'examples' removed: ○ 97110 – Therapeutic Exercise: Strengthening of select muscle groups (beginning in gravity-eliminated plane, if needed) progressing to anti-gravity plane utilizing body weight with progressive resistive exercises utilizing thera-tubing, exercise ball, free weights, etc.; closed chain exercises are often preferable to open chain exercises in preventing shearing forces and simulating functional activities); monitored graded exercise following cardiac or pulmonary surgery or heart attack; selective stretching to increase joint range of motion (ROM). ○ 97112 – Neuromuscular re-education: Treatment involves the stimulation of reflexes, sensation, posture, proprioception and motor activity through rocker/BAPS board, mini-trampolines, targeted exercises to spastic or rigid muscles, balance training, proprioceptive neuromuscular facilitation (PNF), Feldenkrais, Bobath, neurodevelopmental treatment (NDT), and desensitization techniques ○ 97116 – Gait training: Gait training can be useful for people with any condition needing to re-learn proper ambulation to allow for functional performance and mobility. Common conditions include amputation, osteoarthritis, muscular dystrophy, cerebral palsy, stroke, Parkinson's disease, multiple sclerosis, brain/spinal cord injuries, post-surgical, sports injury, and low back pain. ○ 97530 – Therapeutic activities: Activities that address quantifiable deficits (e.g., loss of ROM, strength, or functional capacity) resulting in a deficit in functional mobility. Functional mobility may include bending, reaching, lifting, carrying, pushing, pulling, bed mobility and transfers • Editorial changes – sections moved for better reading flow • References updated
September 2022	• References added • Billing Units: Added "≥" to billing unit descriptions • Therapeutic exercise: Changed "therapist" to "physical medicine provider/practitioner" • Revised CPT code for Cognitive Skills Development • Added information to identify difference between sensory integration and neuromuscular re-education • Minor editorial changes
~~December 2021~~	~~• Added "General Information" statement~~ ~~• Updated billing units according to CMS LCA~~ ~~• Added VBRT under neuromuscular re-education~~ ~~• Clarified support for service for 97761-Prosthetic Training~~

	• ~~Removed Code 97760 cannot be reported with gait training (97116)~~

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Reviewed/Approved by NIA Clinical Guideline Committee

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