

PHYSICAL THERAPY GUIDELINE

These guidelines are an educational tool designed to assist practitioners in providing appropriate care for patients. They are intended to assist in the determination of the number of physical therapy visits needed based on a patient's clinical condition. Physical therapy may be needed due to pain, or inability to perform activities of daily living (ADLs) due to limited function of musculo-skeletal structures. These guidelines do not address limited function due to severe neurologic dysfunction (e.g., developmental delay, stroke, progressive neurologic condition).

This information is provided as a general reference and is not intended to address every aspect of a clinical situation that may exist now, or in the future. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual patients.

Process

The following process will be followed for authorization of physical therapy visits:

- Request for physical therapy should be initiated by the provider. After the patient's assessment, if physical therapy is felt warranted, the referring provider or the recommended therapist should contact VPHP for authorization.
- At that time, a referral coordinator will authorize 1 visit to a physical therapist for an assessment unless the referring provider has evaluated the patient and prescribed specific treatment. In this scenario the recommending provider must submit appropriate clinical documentation to support the prescribed treatment.
- When the member is sent to therapist for assessment, the therapist should contact VPHP if they feel that patient could benefit from therapy. At that time based on the patient's clinical condition, therapy will be authorized with the appropriate clinical documentation. Patients may receive initial therapy as well as additional therapy if warranted and pre approved.
- If a patient has reached the maximum number of approved visits (initial and additional visits as stated in the guideline) and the therapist feels that more visits are indicated, the patient must be sent back to the referring provider for a reassessment. VPHP must receive adequate documentation to justify additional visits. This determination will be made by the Medical Director who may approve additional visits on a case-by-case basis.
- The maximum duration of physical therapy will be 12 weeks unless specifically identified by the criteria.

For the purpose of this document, HEP is an abbreviation for home exercise program. This document provides number of initial as well as additional visits for pre-surgical or non-surgical patients, as well as number of visits for post surgical patients based on body part.

Body Part	Refer To
Thoracolumbar spine	Pages 3-6
Upper thoracic and cervical spine	Pages 7-9
Shoulder	Pages 10-12
Elbow	Pages 13-15
Forearm/wrist	Pages 16-19
Hands and fingers	Pages 20-23
Hip	Pages 24-25
Knee	Pages 26-29
Lower leg/Ankle	Pages 30-33
Foot/Toes	Pages 34-38

Back

Acute Low Back Strain

Pre-surgical or non-surgical, Thoracolumbosacral spine

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits:

1. Strength: diminished (5 = normal, 4 = good, 3 = fair, 2 = poor, 1 = trace)
2. ROM: limited $\geq 30\%$ (AMA Lumbar norms: flexion 60; extension 25; rotation 30; lateral flexion 25 degrees; Thoracic norms: Flexion 40, lateral flexion (side bend) 10, rotation 30 degrees)
3. Pain: referred to sacro-iliac area, buttock, hip, knee, ankle, and/or foot.
4. Neurological signs: altered reflexes and/or sensation; compression signs affecting bowel and bladder function should be referred for immediate medical/surgical intervention.

Diagnosis		Initial Visits	Additional Visits (a)
Acute low back strain		1 + HEP	2 (HEP)

If additional sessions are required, adequate documentation of limitations based on abnormal findings must be provided. Additional sessions will be approved on a case-by-case basis.

Chronic Low Back Pain (LBP)

Pre-surgical or non-surgical, Thoracolumbosacral spine

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits:

5. Strength: diminished (5 = normal, 4 = good, 3 = fair, 2 = poor, 1 = trace)
6. ROM: limited $\geq 30\%$ (AMA Lumbar norms: flexion 60; extension 25; rotation 30; lateral flexion 25 degrees; Thoracic norms: Flexion 40, lateral flexion (side bend) 10, rotation 30 degrees)
7. Pain: referred to sacro-iliac area, buttock, hip, knee, ankle, and/or foot.
8. Neurological signs: altered reflexes and/or sensation; compression signs affecting bowel and bladder function should be referred for immediate medical/surgical intervention.

Diagnosis		Initial Visits	Additional Visits (a)
Ankylosing spondylitis (*) /other spondylopathies		3 to 6 + HEP	6 (*) (HEP)
Compression fracture, vertebra		12 visits (HEP) over 1 to 2 months.	
<i>Dysfunctional Posture with pain or disability - Up to 12 visits (HEP) over 2 months may be necessary.</i>			
		2 to 6 (HEP)	3 (HEP)
Low or mid-back pain, undifferentiated, recurrent, chronic		3 to 6 initially; Up to 12 for back school and HEP supervision	
Lumbar disc, non-surgical	Up to 24 visits (HEP) over 2 months may be necessary. (Ave. is 18 visits over 6 weeks)		
Acute		2 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		6 to 9 (HEP)	3 (HEP)
Thoracic disc	Up to 24 visits (HEP) over 2 months may be necessary.		
Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 6 (HEP)	3 (HEP)
Myofasciitis			
Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic		3 to 6 (HEP)	3 (HEP)
Sacroiliac dysfunction with pain			
Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic		3 to 6 (HEP)	3 (HEP)
Sciatica/Sciatic pain radiation			
Acute		4 to 6 (HEP)	2 to 4 (HEP)
Sub-acute	Up to 16 visits over first 2 months if necessary.		
Chronic, recurrent		9	6
Scoliosis, acquired		6 (HEP)	3 (HEP)
Scoliosis, idiopathic	Medical Director review for medical necessity and # of visits (if any).		
Spina bifida			
Spondylolisthesis with pain - Up to 15 visits may be necessary – more for frail or obese patients.			
Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent		3 to 6 (HEP)	3 (HEP)

Diagnosis		Initial Visits	Additional Visits (a)
Spinal stenosis (refer to footnote)	8 to 12 visits may be necessary – more in frail or obese patients.		
Acute onset symptoms		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 9 (HEP)	3 (HEP)
Chronic, recurrent symptoms		4 to 6 (HEP)	3 (HEP)

Strain/sprain, lumbosacral			
Mild to Moderate: Acute		2 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic, recurrent		6 to 9 (HEP)	3 (HEP)
Severe: Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		6 to 9 (HEP)	3 (HEP)

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

Post-surgical, Thoracolumbosacral spine

Indicators: Same as for pre-surgical or non-surgical lumbar spine preceding section.

Diagnosis		Initial Visits	Additional Visits (a)
Discectomy, arthroscopic			
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		2 to 3 (HEP)	3 (HEP)
Chronic w/complications		2 to 3 (HEP)	3 (HEP)
Discectomy, open, post-op			
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		2 to 3 (HEP)	3 (HEP)
Chronic w/complications		4 to 6 (HEP)	3 (HEP)
Fracture (post ORIF)			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		4 to 6 (HEP)	3 (HEP)
Fusion, lumbar			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		4 to 6 (HEP)	3 (HEP)
Laminectomy, lumbosacral			
Acute		4 to 6 (HEP)	3 (HEP)
Sub Acute		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		4 to 6 (HEP)	3 (HEP)

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These recommendations for additional visits are an approximation of those required where complications are present or the patient has co-morbid conditions that slow progress in therapy – either fewer or more may be required for some individuals. Additional visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

A pre-operative visit, if possible prior to an elective procedure, and post-operative therapy should be authorized for surgical patients concomitantly with the authorization for surgery.

Upper Thoracic and Cervical Spine

Upper thorax & Cervical Spine

Pre-surgical or non-surgical, Cervical spine/Upper Thorax

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of therapy visits unless the request is submitted prior to surgery scheduled for the near future. In that case, post-operative visits may be routinely authorized.

1. Strength: <4/good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited >30% of AMA normal [flexion 60, extension 75, lateral rotation 80, lateral flexion (side bend) 45 degrees] (specify right or left)
3. Pain: referred to upper back, shoulder, arm, and/or hand.
4. Neurological signs: altered reflexes and/or sensations.

agnosis		Initial	Additional
Cervical arthritis, chronic		4 for HEP	3 (HEP)
Cervical disc syndrome – radiculopathy or herniated disc w/o myelopathy – 15 or more visits may be needed.			
Acute		4 to 8 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 6 (HEP)	3 (HEP)
Compression fracture – cervico-thoracic region - Up to 10 visits may be necessary, particularly in frail osteoporotic elderly patients.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		2 to 4 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 6 (HEP)	3 (HEP)
Myofasciitis (cervical; upper back/neck myofascial pain)			
Acute		2 to 6 (HEP)	1 to 2 (HEP)
Sub-acute		2 to 6 (HEP)	1 to 2 (HEP)
Chronic, recurrent symptoms		2 to 6 (HEP)	1 to 2 (HEP)
Scoliosis, Kyphoscoliosis (structural deformity) with pain, spasm			
Acquired		2 to 6 (HEP)	1 to 2 (HEP)
Idiopathic		2 to 6 (HEP)	1 to 2 (HEP)
Infantile		2 to 6 (HEP)	1 to 2 (HEP)
Spondylosis without myelopathy			
Mild to Moderate: Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent		3 to 6 (HEP)	3 (HEP)
Severe		6 to 9 (HEP)	3 (HEP)
Strain/sprain (cervical; trapezius; upper back and neck) – Up to 12 visits during the 4 to 6 weeks may be necessary, particularly if multiple trauma, frail elderly patient. Additional visits depend on progress.			
Mild to Moderate: Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent		3 to 6 (HEP)	3 (HEP)
Severe: Acute *		3 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 6 (HEP)	3 (HEP)
* Whiplash – Up to 18 visits with HEP may be required for a severe whiplash injury (+ a cervical collar, if requested)*			
Stenosis. Cervical – Up to 12 visits may be necessary – more for frail elderly patients			

agnosis		Initial	Additional
Acute		4 to 8 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 6 (HEP)	3 (HEP)
Synovitis			
Acute		4 to 8 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 6 (HEP)	3 (HEP)

Thoracic Outlet Syndrome - Up to 16 visits over 6 to 8 weeks may be necessary for pain, weakness, ROM			
Acute		2 to 6 (HEP)	1 to 2 (HEP)
Sub-acute		2 to 6 (HEP)	1 to 2 (HEP)
Chronic, recurrent symptoms		2 to 6 (HEP)	1 to 2 (HEP)

Additional visits will be authorized *only* if the initial series of visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

* “A semi-hard cervical collar and rest for three to six weeks or physiotherapy accompanied by home exercises for six weeks reduced neck and arm pain substantially compared with a wait and see policy in the early phase of cervical radiculopathy.” (Kuijper, B., Tans, J., et al: Cervical collar or physiotherapy versus wait and see policy for recent onset cervical radiculopathy: randomised trial. *BMJ* 2009;339:b3883)

Post-surgical, Upper Thoracic& Cervical spine

Indicators: Same as for Pre-surgical or non-surgical cervical spine in the preceding section.

6 to 12 post-surgical visits are reasonable and necessary following most procedures. Complex injuries, particularly if an associated head injury, comorbid arthritis, persisting deficits, scarring and other problems may require additional visits over a longer time period.

Diagnosis		Initial Visits	Additional Visits (a)
Discectomy (arthroscopic procedure)			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		2 to 6 (HEP)	3 (HEP)
Chronic w/complications		2 to 6 (HEP)	3 (HEP)
Fracture (post ORIF)			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		2 to 6 (HEP)	3 (HEP)
Chronic w/complications		2 to 6 (HEP)	3 (HEP)
Fusion			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		2 to 6 (HEP)	3 (HEP)
Chronic w/complications		2 to 6 (HEP)	3 (HEP)
Laminectomy			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		2 to 6 (HEP)	3 (HEP)
Chronic w/complications		2 to 6 (HEP)	3 (HEP)

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

Shoulder

Shoulder

Pre-surgical or non-surgical, shoulder

Indicators: One or more of the following findings must be present in order to authorize the initiation of physical therapy visits, unless the request is submitted prior to surgery that has been scheduled for the near future. In that case, post-operative visits may be routinely authorized.

The degree of abnormality should be specified at the initiation of therapy and periodically to establish an objective response to therapy.

1. Strength: ≤ 4 /good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited $\geq 30\%$ (norms: flexion = 180; extension = 50; abduction = 180; internal rotation = 90; external rotation = 90 degrees)
3. Pain: limiting function.
4. Neurological signs: altered reflexes and/or sensations.

Diagnosis		Initial Visits	Additional Visits (a)
Bursitis (rotator cuff, supraspinatus) - Up to 12 visits over 2 months with HEP if medically necessary.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 5 (HEP)	3 (HEP)
Adhesive bursitis/capsulitis w/o frozen shoulder or shoulder joint pain, unspecified diagnosis - Up to 15 visits over 2 months with HEP if medically necessary.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 5 (HEP)	3 (HEP)
Adhesive bursitis/capsulitis with frozen shoulder;			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms	30 or more visits may be required		
Degenerative Joint/Osteoarthritis/Pain NOS Shoulder region - Up to 15 visits over 2 months with HEP if medically necessary.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 5 (HEP)	3 (HEP)
Dislocation, anterior, unstable, non-operated, primary or recurrent			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		3 to 9 (HEP)	3 (HEP)
Impingement			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 5 (HEP)	3 (HEP)
Myofasciitis (e.g., disuse atrophy)			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		3 to 5 (HEP)	3 (HEP)
Strain/Sprain, Shoulder		Up to 9 total visits initially for entire course of care.	
Mild to Moderate: Acute		2 to 4 (HEP)	2 (HEP)
Sub-acute		3 to 10 (HEP)	3 (HEP)
Chronic, recurrent		2 to 4 (HEP)	3 (HEP)

Diagnosis		Initial Visits	Additional Visits (a)
Severe: Acute		2 to 6 (HEP)	2 (HEP)
Sub-acute		3 to 12 (HEP)	3 (HEP)
Chronic, recurrent		2 to 6 (HEP)	3 (HEP)

Diagnosis		Initial Visits	Additional Visits (a)
Tendinitis, adhesive or calcific, shoulder - Up to 12 visits over 2 months (HEP) if medically necessary.			
Acute		2 to 4 (HEP)	2 (HEP)
Sub-acute		3 to 10 (HEP)	3 (HEP)
Chronic, recurrent		2 to 4 (HEP)	3 (HEP)
Thoracic outlet syndrome			
Acute		2 to 6 (HEP)	1 to 2 (HEP)
Sub-acute		2 to 6 (HEP)	1 to 2 (HEP)
Chronic, recurrent		2 to 6 (HEP)	1 to 2 (HEP)

A home exercise program (HEP) is central to the care of shoulder disorders. An exception may be the individual who is unable to participate in self-care and does not have a home caregiver that is cooperative and motivated enough to provide home exercise program assistance for the patient. The teaching for this program should be started on the first day of therapy and continue throughout the formal therapy program with a planned transition. Example exercise instruction sheets are in a separate chapter of this manual. One or two of the approved initial visits should be reserved for follow-up to assess and redirect the home program activities.

Additional visits will be authorized *only* if the initial series of visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

Post-surgical, shoulder

Indicators: Same as for preceding section – non-surgical or presurgical shoulder.

A pre-operative visit, if possible prior to an elective procedure, as well as post-operative therapy should be authorized for surgical patients concomitantly with the initial authorization for surgery.

Diagnosis		Initial Visits	Additional Visits (a)
Acromioplasty: Initial - 8 to 12 visits over 8 weeks; 4 to 6 additional visits.			
Arthroscopy, diagnostic (with or w/o biopsy) - 4 visits over 3 to 4 weeks may be necessary.			
Arthroscopic procedure			
Acute		1 to 3 (HEP)	1 (HEP)
Sub-acute		2 to 4 (HEP)	3 (HEP)
Chronic w/complications		3 to 5 (HEP)	3 (HEP)
Fracture, closed; w/o frozen shoulder involving shoulder, humerus (neck, proximal or distal), clavicle and/or scapula - Up to 30+ visits over 3 months (HEP) if medically necessary.			
Acute		2 to 8 (HEP)	3 (HEP)
Sub-acute		3 to 8 (HEP)	3 (HEP)
Chronic w/complications		3 to 5 (HEP)	3 (HEP)
Fracture, (Post ORIF) w/o frozen shoulder involving shoulder, clavicle or scapula - Up to 20 visits over 3 months (HEP) if medically necessary.			
Acute (Post-op weeks 0 – 4)		2 to 6 (HEP)	3 (HEP)
Sub-acute (Post-op weeks 5 – 12)		3 to 8 (HEP)	3 (HEP)
Chronic, recurrent disability		3 to 5 (HEP)	3 (HEP)
Impingement release		2 to 8 (HEP)	3 (HEP)
Primary dislocation, post-immobilization – 4 to 6 (HEP)			
Rotator cuff repair with distal clavicle resection - Initial: 2 to 3/wk. for 8 weeks; Up to 20 visits over 8 to 16 wks. may be medically necessary. (weeks 0 – 4: 2 to 4 visits; weeks 5 to 8: 3 to 6 visits; weeks 9 to 16: 2 to 4 visits – additional visits as needed that relate to complex injuries, special needs, post-surgical complications) – refer to guidelines that follow in this section.			
Shoulder replacement/Arthroplasty, total	Initial: 12 to 16 (2 to 3/wk. for 3-4 wks., then 1-2/week for 4 weeks – Up to 20 visits over 3 months (HEP) if necessary. More visits may be needed for complex care requirements.		
Bankhart procedure			
Tendon rupture(capsule; rotator cuff) or Shoulder Instability, post-op - Up to 24 visits over 3 months may be medically necessary			
Acute		2 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 8 (HEP)	3 (HEP)
Chronic w/complications		3 to 5 (HEP)	3 (HEP)

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These recommendations for additional visits are an approximation of those required where complications are present or the patient has co-morbid conditions that slow progress in therapy – either fewer or more may be required for some individuals. These visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

Elbow

Elbow/Upper Extremity Region

Pre-surgical or non-surgical, Elbow/Upper extremity

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits unless the request is prior to surgery that has been scheduled for the near future. In that case, post-operative physical medicine visits may be routinely authorized.

1. Strength: <4/good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited >40% (norms: flexion = 60; extension = 75; supination = 80; pronation = 80 side bend = 45 degrees)
3. Pain
4. Neurological signs: altered reflexes and/or sensations.

Diagnosis		Initial Visits	Additional Visits (a)
Bursitis - Up to 20 visits over 2 to 3 months if medically necessary.			
Acute		2 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		1 to 2 (HEP)	2 (HEP)
Cubital tunnel syndrome (ulnar nerve compression or entrapment) *			
Acute		2 to 6 (HEP)	3 (HEP)
Sub-acute		2 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		1 to 2 (HEP)	3 (HEP)
Epicondylitis/forearm strain (lateral or tennis elbow; medial or golfer's elbow/little leaguer's elbow) * Up to 12 visits may be required if necessary. Average is 10 visits over 3 to 4 weeks. – refer to additional information following this section regarding treatment options.			
Acute		2 to 4 (HEP)	1-2 (HEP)
Sub-acute		2 to 4 (HEP)	1-2 (HEP)
Chronic, recurrent symptoms		1 to 2 (HEP)	1-2 (HEP)
Fracture (post-cast removal, closed) including arm or forearm fractures - Up to 30 visits over 3 months if medically necessary.			
Acute (2 to 3/wk. X 4 weeks)		8 to 12 (HEP)	3 (HEP)
Sub-acute (1/wk. X 4 to 6 weeks))		4 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		1 to 2 (HEP)	2 (HEP)
Sprains/strains (radiohumeral, radioulnar, ulnohumeral) - Up to 9 visits over 1 to 2 months if medically necessary.			
Acute		2 to 6 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic, recurrent symptoms		1 to 2 (HEP)	2 (HEP)

Refer to specific condition guidelines following the post-surgical treatment visit table.

Post-surgical, Elbow/Upper extremity

Indicators: same as in preceding section, pre-surgical or non-surgical elbow.

Diagnosis		Initial Visits	Additional Visits (a)
Amputation, upper extremity			
Stump healing management, whirlpool, therapeutic exercise; strength training, bandaging, prosthetic training, home evaluation, and related services		20 to 24 treatments over 4 months following any stump revision; additional visits for new prosthesis.	
Arthroscopic procedures			
Acute		2 to 3 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic w/complications		1 to 2 (HEP)	2 (HEP)
Collateral ligament repair (lateral, medial)			
Acute		2 to 5 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic w/complications		1 to 2 (HEP)	2 (HEP)
Fascial release (i.e. tennis elbow release)			
Acute		2 to 5 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic w/complications		1 to 2 (HEP)	2 (HEP)
Fracture (with ORIF) - Up to 30 visits over 3 months if medically necessary for complicated or multiple trauma injuries. Average # of visits is 24 over two months.			
Acute		8 to 12 (HEP)	3 (HEP)
Subacute		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		1 to 2 (HEP)	2 (HEP)
Nerve transposition (i.e., ulnar nerve)			
Acute		2 to 5 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic w/complications		1 to 2 (HEP)	2 (HEP)
Primary dislocation		4: HEP	2 (HEP)
Total elbow replacement/Arthroplasty - Up to 30 visits over 3 months post-discharge, if medically necessary.			
Acute		12 (HEP)	6 (HEP)

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These recommendations for additional visits are an approximation of those required where complications are present or the patient has co-morbid conditions that slow progress in therapy – either fewer or more may be required for some individuals. Additional visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

A home exercise program (HEP), individually prescribed, is central to the care of patients who have extremity disorders. The teaching for this program should be started on the first day of therapy and continue throughout the formal therapy program with a planned transition.

One or two of the approved initial visits should be used for follow-up to assess and redirect the home program activities. A pre-operative visit, if possible prior to an elective procedure, and post-operative therapy should be authorized for surgical patients concomitantly with the authorization for surgery.

Forearm/Wrist

Pre-surgical or non-surgical, Forearm/wrist

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits unless the request is prior to surgery scheduled for a certain date in the near future. In that case, post-operative physical medicine visits may be routinely authorized.

1. Strength: <4/good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited >30% (AMA wrist norms: flexion 60; extension 60; ulnar deviation 30, radial deviation 20; supination 80 degrees; AMA forearm norms: Pronation 80, Supination 80 degrees)
(AAOS digit norms: metacarpal phalangeal (MP) 0-90; proximal interphalangeal (PIP) 0-100; distal interphalangeal (DIP) 0-70; Thumb norms: MP 0-60; IP 0-80, radial abduction 50 degrees; adduction 0 cm, opposition 8 cm)
3. Pain
4. Neurological signs: (altered reflexes and/or sensations)

Diagnosis		Initial Visits	Additional Visits (a)
Carpal tunnel syndrome - Up to 16 visits over 2 to 3 months if medically necessary			
Acute (includes splinting, home instructions)		6 to 8 (HEP)	1 to 2 (HEP)
Sub-acute		4 to 6 (HEP)	1 to 2 (HEP)
Chronic, recurrent symptoms	6; (therapy may not be helpful if long-standing condition)		
Degenerative joint disease/Osteoarthritis		6; HEP	6
Reflex Sympathetic Dystrophy (RSD)		3; HEP	1 to 2 or more
Strains/sprains - Up to 9 visits over 1 to 2 months if medically necessary.			
Mild to Moderate			
Acute		2 to 4 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic, recurrent symptoms		1 to 2 (HEP)	2 (HEP)
Severe: Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		3 to 4 (HEP)	3 (HEP)
Chronic, recurrent symptoms		2 to 4 (HEP)	3 (HEP)
Synovitis			
Acute		2 to 4 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic, recurrent symptoms		1 to 2 (HEP)	2 (HEP)
Tendinitis, calcific - Up to 16 treatments over 1 to 2 months if medically necessary.			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)
Chronic, recurrent symptoms		6 to 8 (HEP)	3 (HEP)
Tendinitis (extensor/flexor digitorum longus) - Up to 12 visits over 2 months if medically necessary.			
Acute		2 to 5 (HEP)	2 (HEP)
Sub-acute		2 to 4 (HEP)	2 (HEP)
Chronic		1 to 2 (HEP)	2 (HEP)

Diagnosis		Initial Visits	Additional Visits (a)
<i>Tenosynovitis</i>	12 treatments are usually sufficient – more may be necessary.		
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)
Chronic		6 to 8 (HEP)	3 (HEP)

Post-surgical, Lower arm/wrist

Indicators: same as for the preceding section, pre-surgical or non-surgical wrist.

Diagnosis		Initial Visits	Additional Visits (a)
Arthroscopic procedure		Refer to rehabilitation guideline links that follow	
Acute, subacute		4 (HEP)	3 (HEP)
Chronic w/complications		6 to 8 (HEP)	4 (HEP)
Carpal tunnel release (CTR), endoscopic – Up to 12 visits may be needed over 2 months for an uncomplicated post-op course of care.			
Acute (weeks 0 to 2)		4 (HEP)	3 (HEP)
Sub-acute (weeks 3 to 6)		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		6 – 12 (HEP)	6 (HEP)
Carpal tunnel release (CTR), open surgical procedure – Up to 16 visits over several months may be needed for an uncomplicated post-op course. Therapy may not be appropriate to initiate immediately postop. Additional visits may be required for complex care requirements – refer to guideline.			
Acute (weeks 0 to 2)		3 to 6 (HEP)	3 (HEP)
Sub-acute (weeks 3 to 6)		4 to 8 (HEP)	3 (HEP)
Chronic w/complications		6 – 12+ (HEP)	6 (HEP)
Entrapment release, ulnar nerve			
Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 8 (HEP)	3 (HEP)
Chronic w/complications		6 – 12 (HEP)	6 (HEP)
Entrapment release, radial nerve			
Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 8 (HEP)	3 (HEP)
Chronic w/complications		6 – 12 (HEP)	6 (HEP)
Fracture, distal arm – 8 to 20 visits over two months may be necessary after cast removal depending on complexity, medical necessity. Average # of visits is 16 over two months.			
Closed		4 to 6 (HEP)	3 (HEP)
Open		6 to 8 (HEP)	3 (HEP)
Joint replacement – wrist and/or hand or fingers – same extremity - Up to 40 visits over 3 months if medically necessary.			
Muscle repair			
Acute		3 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 8 (HEP)	3 (HEP)
Chronic w/complications		6 – 12 (HEP)	6 (HEP)
Open wound (wrist or hand) with tendon involvement – 36 visits over several months may be necessary.			
Tendon repair, flexor * - Initial post-op authorization for 12 visits total			
Acute (0 to 3 weeks)		6 to 9 (HEP)	3 (HEP)
Sub-acute (4 to 6 weeks)		4 to 6 (HEP)	3 (HEP)
Progressive care (7 to 12 weeks)		2 to 6 (HEP)	3 (HEP)

* Post-op protocol includes splinting. An occupational therapist specializing in the hand should be a provider for the care of wrist and hand injuries or post-op procedures whenever possible.

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These recommendations for additional visits are an approximation of those required where complications are present or the patient has co-morbid conditions that slow progress in therapy – either fewer or more may be required for some individuals. Additional visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

Post-surgical wrist continued

A home exercise program (HEP), individually prescribed, is central to the care of patients who have wrist and hand disorders. The teaching for this program should be started on the first day of therapy and continue throughout the formal therapy program with a planned transition. One or two of the approved initial visits should be used for follow-up to assess and redirect the home program activities.

Hands and Fingers

Hand/Fingers

Pre-surgical or non-surgical, hand including fingers

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of therapy visits (OT or PT) visits.

1. Strength: ≤ 4 /good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited $\geq 40\%$ (AMA wrist norms: flexion 60; extension 60; ulnar deviation 30, radial deviation 20; supination 80 degrees; AMA forearm norms: Pronation 80, Supination 80 degrees)
(AAOS digit norms: metacarpal phalangeal (MP) 0-90; proximal interphalangeal (PIP) 0-100; distal interphalangeal (DIP) 0-70; Thumb norms: MP 0-60; IP 0-80, radial abduction 50 degrees; adduction 0 cm, opposition 8 cm)
3. Pain: grip strength limited $\geq 25\%$.
4. Neurological signs: altered reflexes and/or sensations.

When the request is submitted prior to a planned or scheduled surgery, post-operative physical medicine or hand OT visits should be routinely authorized to avoid any delays in the start of therapy.

Diagnosis		Initial Visits	Additional Visits (a)
Fracture (post-cast removal; navicular; metacarpal)			
Acute + subacute over 2 months		4 to 6 (HEP)	4 (HEP)
Chronic w/complications		10 to 12 (HEP)	6 (HEP)
Dupuytren's contracture(s) (non-surgical)		4 (HEP)	1 to 2 (HEP)
Nerve entrapment, ulnar			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)
Chronic w/recurrent symptoms		6 to 8 (HEP)	3 (HEP)
PIP joint injuries – Up to 16 visits over 2 to 3 months may be necessary – up to 20 if a dislocation			
Acute		6 to 8 (HEP)	2 (HEP)
Sub-acute		4 to 8 (HEP)	2 (HEP)
Chronic w/complications		2 to 8 (HEP)	2 (HEP)
Reflex Sympathetic dystrophy – up to 30 visits may be needed – more if contracture, edema, special occupational needs, pain persists			
Acute		6 to 12 (HEP)	6 (HEP)
Sub-acute		8 to 12 (HEP)	6 (HEP)
Chronic w/complications		8 to 16 (HEP)	6 (HEP)
Strains/sprains			
Acute		6 to 8 (HEP)	2 (HEP)
Sub-acute		4 to 8 (HEP)	2 (HEP)
Chronic w/recurrent symptoms		2 to 8 (HEP)	2 (HEP)
Synovitis			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)
Chronic w/recurrent symptoms		6 to 8 (HEP)	3 (HEP)
Tendinitis (digitorum longus)			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)

Diagnosis		Initial Visits	Additional Visits (a)
Chronic w/recurrent symptoms		6 to 8 (HEP)	3 (HEP)
Tenosynovitis; including radial styloid, de Quervain's (DeQuervain's)			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)
Chronic w/recurrent symptoms		6 to 8 (HEP)	3 (HEP)

Post-surgical, Hand including fingers

Indicators: same as preceding section, pre-surgical or non-surgical hand.

Diagnosis		Initial Visits	Additional Visits (a)
Finger joint replacement		9 to 12 (HEP)	3 to 6 (HEP)
Fracture, metacarpal (post ORIF) – 8 to 14 visits over two months may be necessary after cast removal			
Closed		4 to 6 (HEP)	3 (HEP)
Open		6 to 8 (HEP)	3 (HEP)
Fracture, phalanges, complex, open (Post ORIF) - Up to 6 visits over 1 to 2 months if medically necessary.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		6 to 8 (HEP)	3 (HEP)
Fracture, multiple, wrist & hand region (Post ORIF) - Up to 12 visits over 1 to 2 months if medically necessary.			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)
Chronic w/complications		6 to 8 (HEP)	3 (HEP)
Joint Reconstruction - Up to 30 visits over 3 months if medically necessary.			
Ligament repair/reconstruction (post rupture) * - Up to 24 visits over 2 months if medically necessary.			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		6 to 8 (HEP)	3 (HEP)
Chronic w/complications		6 to 8 (HEP)	3 (HEP)
Nerve entrapment release, carpal tunnel (median nerve) – refer preceding to Forearm/wrist section			
Open wound (wrist or hand) with tendon involvement – 36 visits over 1 to 2 months may be necessary.			
Reconstructive hand surgery – 36 treatments over 3 months may be necessary.			
Tendon graft/repairs: 26420 – up to 36 visits over 2 to 3 months if medically necessary.			
Tendon repair, extensor *			
Acute		6	6
Chronic w/complications		12	8
Tendon repair, flexor * - Initial: 12 to 15 visits progressing from PROM to resistive AROM.			
Acute (0 to 3 weeks)		4 to 6 (HEP)	3 (HEP)
Sub-acute (4 to 6 weeks)		4 to 6 (HEP)	3 (HEP)
Progressive care (7 to 12 weeks)		2 to 6 (HEP)	3 (HEP)
Tendon repair, trigger finger *			
Acute		1	0
Chronic w/complications		2 (HEP)	1 (HEP)
Total Joint Replacement Arthroplasty - Up to 40 visits over a 3-month period may be medically necessary.			
Tenosynovitis; de Quervain's (DeQuervain's) Post-op – Up to 20 visits may be necessary for an uncomplicated course – more with complications.			
Acute (weeks 1 to 4)		4 to 8 (HEP)	3 (HEP)
Sub-acute (weeks 5 to 8)		6 to 8 (HEP)	3 (HEP)
Progressive care (weeks 9 to 12)		2 to 4 (HEP)	3 (HEP)

Post-op protocols require or may require splinting. An occupational therapist (hand therapist, when available) should be a therapy provider for the care of injuries or following procedures to the wrist and hand areas.

Additional visits are for an impaired range of motion and will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These recommendations for additional visits are an approximation of those required where complications are present or the patient has co-morbid conditions that slow progress in therapy – either fewer or more may be required for some individuals. Additional visits will *not* be authorized retrospectively, and approved on a case-by-case basis..

A home exercise program (HEP), individually prescribed, is central to the care of patients who have disorders of an extremity. The teaching for this program should be started on the first day of therapy and continue throughout the formal therapy program with a planned transition. One or two of the approved initial visits should be used for follow-up to assess and redirect the home program activities.

Hip

Pre-surgical or Non-surgical, Hip

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits.

1. Strength: ≤ 4 /good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited $\geq 30\%$ (norms: flexion = 125; extension = 0; abduction = 30 degrees)
3. Pain
4. Neurological signs: altered reflexes and/or sensations.

When the request is prior to surgery that has been scheduled within a reasonable future period of time, post-operative physical medicine visits may be routinely authorized.

Diagnosis		Initial Visits	Additional Visits (a)
Bursitis, Sprains, Strains (adductor/groin pull; gluteal; hamstring; tensor fascia latae)	Up to 12 visits over 2 months with HEP if necessary.		
Mild to moderate: Acute		2 to 6: HEP	3 (HEP)
Sub-acute		4 to 6: HEP	3 (HEP)
Chronic, recurrent symptoms		4 to 8: HEP	3 (HEP)
Severe: Acute		N/A	N/A
Sub-acute		6 to 9: HEP	3 (HEP)
Chronic, persistent or recurrent symptoms		10 to 12: HEP	3 (HEP)
Degenerative joint disease, hip		4 to 8: HEP	0
Tendinitis (adductor; gluteal; hamstring; psoas; iliotibial band)	Up to 12 visits over 1 to 2 months if medically necessary		
Acute		6	3
Sub-acute		8	4
Chronic, recurrent symptoms		8	4
Tenosynovitis			
Acute		6	3
Sub-acute		8	4
Chronic, recurrent symptoms		10	6

Refer to the 'Prehab' section earlier in this manual.

Post-surgical, hip and pelvis

Indicators: same as preceding section, pre-surgical or non-surgical hip.

Diagnosis (# of PT treatments begins at hospital discharge)		Initial Visits	Additional Visits (a)
Fracture, pelvis Up to 12 visits over 1 to 2 months may be medically necessary – more in frail persons or with multiple trauma. Case management recommended for most patients.			
Fracture, hip - post-repair - Visits for average <65 years adult with uncomplicated fracture * (refer to total hip replacement visits section that follow)			
Conservative treatment, closed (non-weight bearing)		4 to 8: HEP	12-20 (HEP)
Conservative treatment, open (weight bearing)		4 to 8:HEP	4 to 8 (HEP)
Total hip replacement for chronic pain limiting activity due to osteoarthritis or post-injury; post-fracture ***		24 or more visits over 3 or 4 months may be necessary in frail persons or those with comorbid conditions. Case management recommended.	
❖	Acute, post-discharge	3 to 6 (HEP)	3 (HEP)
❖	Sub-acute, post-discharge (weeks 2 to 8)	6 to 9 (HEP)	3 (HEP)
❖	Postop weeks 8 to 14 without complications	4 to 6 (HEP)	3 (HEP)
❖	Chronic w/complications - visits after 15 weeks post-op	4 to 6 (HEP)	3 (HEP)

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These recommendations for additional visits are an approximation of those required where complications are present or the patient has co-morbid conditions (e.g., frail, obese, CHF) that slow progress in therapy – either fewer or more may be required for some individuals. Additional visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

Knee

Pre-surgical or non-surgical, knee/leg

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits unless the request is prior to surgery in the near future. In that case, post-operative physical medicine visits may be routinely authorized and it is recommended that one pre-operative visit be authorized as well.

1. Strength: < good.
2. Range of Motion: limited- ≥ 30 percent (AMA Norms: flexion 0 to 135; extension 0 degrees)
3. Pain.
4. Neurological signs: altered reflexes and/or sensations.

Diagnosis		Initial Visits	Additional Visits (a)
Ankylosis/ Contracture/Stiffness	Up to 9 visits over a 2 to 3 month period if necessary.		
Bursitis, patellar	Up to 24 visits over a 2 to 3 month period if necessary *		
Acute		6 (HEP)	3 (HEP)
Sub-acute		6 (HEP)	4 (HEP)
Chronic, recurrent symptoms		8 (HEP)	4 (HEP)
Degenerative joint disease – Osteoarthritis (protocol examples follow)		3 (HEP)	3 (HEP)
Derangement, ACL			
Acute		9 (HEP)	3 (HEP)
Sub-acute		9 (HEP)	3 (HEP)
Chronic, recurrent symptoms		9 (HEP)	3 (HEP)
Derangement, PCL			
Acute		5 (HEP)	3 (HEP)
Sub-acute		8 (HEP)	4 (HEP)
Chronic, recurrent symptoms		10 (HEP)	4 (HEP)
Derangement, lateral collateral			
Acute		5 (HEP)	3 (HEP)
Sub-acute		8 (HEP)	4 (HEP)
Chronic, recurrent symptoms		10 (HEP)	4 (HEP)
Derangement, medial collateral			
Acute		5 (HEP)	3 (HEP)
Sub-acute		8 (HEP)	4 (HEP)
Chronic, recurrent symptoms		10 (HEP)	4 (HEP)
Derangement, lateral meniscus			
Acute		5 (HEP)	3 (HEP)
Sub-acute		8 (HEP)	4 (HEP)
Chronic, recurrent symptoms		10 (HEP)	4 (HEP)
Derangement, medial meniscus			
Acute		5 (HEP)	3 (HEP)
Sub-acute		8 (HEP)	4 (HEP)
Chronic, recurrent symptoms		10 (HEP)	4 (HEP)

Knee

Non-surgical knee disorders (continued)

Myositis (adductor; gluteal; hamstring; iliopsoas; psoas)			
Acute		3 (HEP)	3 (HEP)
Sub-acute		6 (HEP)	4 (HEP)
Chronic, recurrent symptoms		9 (HEP)	5 (HEP)
Myositis, ossificans			
Acute		5 (HEP)	3 (HEP)
Sub-acute		7 (HEP)	4 (HEP)
Chronic, recurrent symptoms		9 (HEP)	5 (HEP)
Patello-femoral instability/pain syndrome/Chondromalacea	Refer to section that follows tables – prolonged therapy may be necessary.		
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		2 to 6 HEP	3 (HEP)
Chronic, recurrent symptoms		6 HEP	3 (HEP)
Patellar subluxation		6+ (HEP)	3+ (HEP)
Reflex Sympathetic Dystrophy (RSD)		3 (HEP)	varies
Strains/sprains knee region (hamstring; quad; adductor; tensor fascia latae or iliotibial band syndrome); – up to 12 visits over 1 to 2 months may be medically necessary for mild to moderate strains and sprains – more visits may be needed for severe injuries, or in frail or obese patients.			
Mild to Moderate: Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		2 to 4 (HEP)	3 (HEP)
Chronic, recurrent symptoms		4 to 6 (HEP)	3 (HEP)
Severe: Acute		N/A	N/A
Sub-acute		8 to 10 (HEP)	4 (HEP)
Chronic, recurrent symptoms		10 to 12 (HEP)	4 (HEP)
Tendinitis (hamstring) - Up to 12 visits over 1 to 2 months may be medically necessary.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		2 to 4 (HEP)	3 (HEP)
Chronic, recurrent symptoms		4 to 6 (HEP)	3 (HEP)
Tendinitis, iliotibial band syndrome; pes anserinus Up to 12 visits over 2 months may be medically necessary in frail or obese patients.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		2 to 4 (HEP)	3 (HEP)
Chronic, recurrent symptoms		4 to 6 (HEP)	3 (HEP)
Tendinitis, patellar Up to 12 visits over 1 to 2 months may be medically necessary.			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic, recurrent symptoms		4 to 6 (HEP)	3 (HEP)
Tendinitis, Achilles or posterior tibialis (shin splints) - Up to 12 visits over a 2 month period may be medically necessary – a home exercise program (HEP) should be started ASAP.			
Acute		2 to 3 (HEP)	3 (HEP)
Sub-acute		4 to 7 (HEP)	3 (HEP)
Chronic/Recurrent		4 to 7 (HEP)	3 (HEP)

Post Surgery - Knee

Indicators: same as for preceding section, pre-surgical or non-surgical knee. One pre-operative visit for non-emergency procedures may be useful to instruct the patient and set expectations for post-op care.

Diagnosis		Initial Visits	Additional Visits (a)
Amputation, AKA or BKA with subsequent prosthesis (More visits may be required for AKA than listed)		6 to 9	4 to 6 (HEP)
Anterior cruciate ligament (ACL) Repair/Reconstruction	Refer to the detailed representative protocols that follow in this section.		
Arthroscopic procedures, knee - meniscal repair follows	1 pre-operative visit may be useful for therapy instruction. Up to 9 visits post-procedure may be necessary.		
Acute (3 to 7 days post-op)		1 to 2 (HEP)	0
Sub-acute		2 to 6 (HEP)	3 (HEP)
Chronic w/complications		1 to 2 (HEP)	3 (HEP)
Derangement, surgical repair			
Acute		6 to 12 (HEP)	6 (HEP)
Sub-acute		6 to 12 (HEP)	6 (HEP)
Chronic		6 to 12 (HEP)	6 (HEP)
Fracture, post-cast removal; (e.g., femoral; patellar; tibial plateau)	– up to 40 visits over 3 to 4 months may be medically necessary, particularly following complex fractures or for frail or obese patients.		
Stress fractures, knee		3 (HEP)	1 to 2 (HEP)
Closed		6 to 9 (HEP)	4 (HEP)
Open		10 to 12 (HEP)	6 (HEP)
Meniscal repair, knee: 1 pre-operative visit may be useful for therapy instruction. Additional postop visits will be required for complex procedures – refer to the following guideline resource.			
Acute (simple) (1 to 2 weeks post-op)		2 to 4 (HEP)	0
Sub-acute (simple) (3 to 4+ weeks post-op)		2 to 4 (HEP)	3 (HEP)
Posterior Cruciate Ligament Reconstruction - Up to 30 visits over 9 to 12 months may be necessary			
Weeks 0 to 3 post-op		2 to 4 (HEP)	3 (HEP)
Weeks 4 to 6 post-op		2 to 4 (HEP)	3 (HEP)
Weeks 7 to 12 post-op		2 to 6 (HEP)	3 (HEP)
Months 4 to 6 post-op		4 to 10 (HEP)	3 (HEP)
Months 7 to 12+ post-op		1 to 3 (HEP)	3 (HEP)
Total Knee Replacement * refer to TKR section that follows Up to 20 to 30 visits post-discharge over 3 months may be necessary for complex care requirements.			
Acute (1 to 5 days post-op)		4 to 6 (HEP)	
Sub-acute (1 to 6 weeks post-op)		6 to 8 (HEP)	6 (HEP)
w/complications, co-morbidities		8 to 12 (HEP)	6 (HEP)

Additional visits will be authorized *only* if initial visits demonstrate measurable objective and documented subjective progress, *or* for a documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These recommendations for additional visits are an approximation of those required when complications are present, in complex situations or the patient has co-morbid conditions that slow progress in therapy – either fewer or more may be required for some individuals. Additional visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

NOTE: A home exercise program (HEP), individually prescribed, is central to the care of patients who have disorders of an extremity. The teaching for this program should be started pre-op or on the first day of therapy and continue throughout the formal therapy program with a planned transition. One or two of the approved initial visits should be used for follow-up to assess and redirect the home program activities.

Lower Leg/Ankle

Lower Leg/Ankle

Pre-surgical or non-surgical, Lower leg/Ankle

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits unless the request is submitted prior to a surgery scheduled for the near future. In that case, post-operative physical medicine visits may be routinely authorized. One pre-operative assessment and visit may be helpful.

1. Strength: ≤ 4 /good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited $\geq 30\%$ (AMA norms: dorsiflexion = 15 w/knee flexed; 10 in subtalar neutral w/knee extended; plantar flexion = 40 degrees)
3. Pain
4. Neurological signs: altered reflexes and/or sensations.

Diagnosis		Initial Visits	Additional Visits (a)
Bursitis/Tendinitis, Achilles or posterior tibialis (shin splints)	Up to 12 visits over a 1 to 2 month period may be medically necessary if initial conservative treatment measures fail – a home exercise program (HEP) should be started ASAP.		
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		4 to 7 (HEP)	3 (HEP)
Chronic/Recurrent		4 to 7 (HEP)	3 (HEP)
Claudication – refer to protocol that follows	Up to 6 visits to supervise and support a HEP over a 6-month period may be medically necessary.		
Degenerative joint disease		2 to 6 (HEP)	3 (HEP)
Diabetic w/foot abnormalities		2 to 6 (HEP)	3 (HEP)
Reflex sympathetic dystrophy		4 to 6 (HEP)	3 (HEP)
Sprains/strains/instability [refer to post-surgical section for post-surgical care guidelines for sprain]	Up to 4 visits over a 1 to 2 month period may be initially medically necessary if initial conservative treatment measures fail – a home exercise program (HEP) should be started ASAP. Refer to the protocol and related information that follows.		
Mild to Moderate			
Acute		1 to 3 (HEP)	2 (HEP)
Sub-acute		1 to 3 (HEP)	2 (HEP)
Chronic, recurrent		3 for HEP	3 (HEP)
Severe: Acute		NA	NA
Sub-acute		3 to 4 (HEP)	3 (HEP)
Chronic, recurrent		3 for HEP	3 to 4 (HEP)
Synovitis - Up to 6 visits over a 1 to 2 month period may be medically necessary if initial conservative treatment measures fail – a home exercise program (HEP) should be started ASAP.			
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		3 to 4 (HEP)	3 (HEP)
Chronic		3 to 4 (HEP)	3 (HEP)
Tarsal tunnel syndrome - Up to 12 visits over a 1 to 2 month period may be medically necessary if initial conservative treatment measures fail – a home exercise program (HEP) should be started ASAP.			
Acute		2 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 7 (HEP)	3 (HEP)
Chronic		4 to 7 (HEP)	3 (HEP)
Tendinitis – ankle,	Up to 12 visits over a 1 to 2 month period may be medically necessary if		

Diagnosis		Initial Visits	Additional Visits (a)
foot region	initial conservative treatment measures fail – a home exercise program (HEP) should be started ASAP.		
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		3 to 7 (HEP)	3 (HEP)
Chronic		3 to 7 (HEP)	3 (HEP)

Tenosynovitis	Up to 12 visits over a 1 to 2 month period may be medically necessary if initial conservative therapies fail – a home exercise program (HEP) should be started ASAP.		
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		3 to 7 (HEP)	3 (HEP)
Chronic		3 to 7 (HEP)	3 (HEP)
Venous stasis ulcers	Up to 6 visits over a 1 month period may be medically necessary, more in complex or long-term chronic cases.		

HEP = Home Exercise Program instruction

Post-surgical, lower leg/ankle

Indicators: same as preceding section, pre-surgical or non-surgical ankle. One pre-operative visit for non-emergency procedures may be useful to instruct the patient and set expectations for post-op care.

Diagnosis		Initial Visits	Additional Visits (a)
Amputation, lower extremity			
Stump healing management, whirlpool, therapeutic exercise; Balance and coordination, strength training, gait training, prosthetic training, home evaluation, and related services		24 treatments over 3 months following any stump revision or new prosthesis.	
Arthroscopic procedures - # of visits must be adapted to extent of procedure, nature of disorder.			
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		4 to 6 (HEP)	3 (HEP)
Lower leg fracture; tibia and/or fibula, closed - Up to 30 visits over a 3 month period may be medically necessary– a home exercise program (HEP) should be started ASAP..			
Acute (weeks 1 to 2)		3 to 6 (HEP)	3 (HEP)
Subacute (weeks 3 to 8)		3 to 6 (HEP)	3 (HEP)
Progressive (weeks 9 to 12)	Strengthening program	3 to 6 (HEP)	3 (HEP)
Fracture (post ORIF, Tibial) - Up to 30 visits over a 3 month period may be medically necessary for a complex fracture – a home exercise program (HEP) should be started ASAP..			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute	Weeks 6 to 12 post-op	4 to 6 (HEP)	3 (HEP)
Chronic w/complications		4 to 6 (HEP)	3 (HEP)
Ankle (trimalleolar) fracture(post cast removal) - Up to 24 visits over a 3 month period may be medically necessary – a home exercise program (HEP) should be started ASAP.			
Closed	9 to 12 total visits – beginning ~ week 6.	6 (HEP)	3 (HEP)
Open		6 (HEP)	3 (HEP)
Ligament reconstruction/repair	Initial: 10 to 12 - A HEP should be started ASAP.	Up to 24 more visits over a 3-month period may be necessary, more w/complications.	
Muscle repair (post rupture triceps; gastrocnemius and/or soleus; tibialis; peroneal)			
Acute		4 to 6 (HEP)	6 (HEP)
Sub-acute		4 to 6 (HEP)	6 (HEP)
Chronic w/complications		8 to 10 (HEP)	6 (HEP)
Reconstructive Procedures			
Acute		0 to 3 (HEP)	3 (HEP)
Sub-acute		0 to 6 (HEP)	3 (HEP)
Chronic w/complications		0 to 6 (HEP)	4 (HEP)
Tarsal tunnel release			
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic w/complications		4 to 6 (HEP)	4 (HEP)
Tendon repair (post-rupture Achilles; peroneal; tibial)	Up to 36 visits over a 3 month period may be medically necessary, particularly in complex conditions, obese, frail or elderly.		

Diagnosis		Initial Visits	Additional Visits (a)
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	6 (HEP)
Chronic if necessary for complications or complex conditions		4 to 6 (HEP)	6 (HEP)
Total joint replacement arthroplasty	Up to 36 visits over a 4 month period may be medically necessary with gait training, particularly in a frail and/or elderly patient. Refer to example protocol that follows.		

(a) Additional visits will be authorized *only* if initial visits demonstrate measurable objective and subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. These visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

A home exercise program (HEP), individually prescribed, is central to the care of patients who have disorders of an extremity. The teaching for this program should be started on the first day of therapy and continue throughout the formal therapy program with a planned transition. One or two of the approved initial visits should be used for follow-up to assess and redirect the home program activities.

Foot/Toes

Foot/toes

Pre-surgical or non-surgical, foot including toes

Indicators: One or more of the following abnormal findings must be present in order to authorize the initiation of physical medicine visits unless surgery is scheduled for the near future. In that case, requests for pre and post-op therapy may be approved at the same time to avoid any delay in the initiation of therapy following surgery.

1. Strength: ≤ 4 /good (5 = normal; 4 = good; 3 = fair; 2 = poor; 1 = trace)
2. ROM: limited $\geq 30\%$ (AMA norms: plantar flexion = 25; dorsiflexion = 10 in subtalar neutral w/knee extended or 15 w/knee flexed; hallux dorsiflexion = 60; extension = 40 degrees)
3. Pain
4. Neurological signs: altered reflexes and/or sensations.

Diagnosis		Initial Visits	Additional Visits (a)
Bursitis, foot	Up to 12 visits over a 2 month period may be medically necessary		
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic		4 to 6 (HEP)	3 (HEP)
Bursitis, toe			
Acute		0 to 4 (HEP)	3 (HEP)
Sub-acute		2 to 4 (HEP)	3 (HEP)
Chronic		2 to 4 (HEP)	3 (HEP)
Capsulitis	Up to 12 visits over a 2 month period may be medically necessary		
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic		4 to 6 (HEP)	3 (HEP)
Fasciitis, plantar	Up to 10 visits to supervise and support a HEP over a 6 month period may be medically necessary.		
Acute		2 to 4 (HEP)	3 (HEP)
Sub-acute/chronic		2 to 6 (HEP)	3 (HEP)
Fracture, toe	No therapy visits are necessary for fracture of a toe without other related foot injuries or unusual complications.		
Metatarsalgia			
Acute		4 to 6 (HEP)	3 (HEP)
Sub-acute		4 to 6 (HEP)	3 (HEP)
Chronic		4 to 6 (HEP)	4 (HEP)
Metatarsalgia, Morton's neuroma	Note guideline that follows this section.		
Acute		3 (HEP)	0
Sub-acute		0	0
Chronic		0	0
Myofasciitis			
Acute		6 (HEP)	3 (HEP)
Sub-acute		6 (HEP)	6 (HEP)
Chronic		9 (HEP)	4 (HEP)
Pes cavus, Pes planovalgus, or Pes planus		3 (HEP)	
Plantar Nerve Disorders		3 (HEP)	

Foot/toes

Strains/sprains:	Up to 12 visits over a 1 to 2 month period may be medically necessary for mild to moderate injuries – more for severe.		
Mild to Moderate			
Acute		3 (HEP)	3 (HEP)
Sub-acute		6 (HEP)	3 (HEP)
Chronic		6 (HEP)	3 (HEP)
Severe/chronic			
Acute visit period		6 (HEP)	3 (HEP)
Sub-acute		9 (HEP)	6 (HEP)
Chronic		12 (HEP)	6 (HEP)
Synovitis			
Acute		6 (HEP)	3 (HEP)
Sub-acute		6 (HEP)	4 (HEP)
Chronic		10 (HEP)	6 (HEP)
Tarsal tunnel syndrome	up to 12 visits over a 1 to 2 month period may be medically necessary.		
Acute		6 (HEP)	3 (HEP)
Sub-acute		8 (HEP)	4 (HEP)
Chronic		8 (HEP)	4 (HEP)
Tendinitis	up to 12 visits over a one-month period may be medically necessary.		
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		4 to 7 (HEP)	3 (HEP)
Chronic		8 (HEP)	3 (HEP)
Tenosynovitis			
Acute		1 to 3 (HEP)	3 (HEP)
Sub-acute		4 to 7 (HEP)	4 (HEP)
Chronic		8 (HEP)	6 (HEP)

Post-surgical, foot including toes

Indicators: same as preceding section, presurgical or nonsurgical foot

A pre-operative visit, if possible prior to an elective procedure, and post-operative therapy should be authorized for surgical patients concomitantly with the authorization for surgery.

Diagnosis		Initial Visits	Additional Visits (a)
Bunionectomy (crutches) - Up to 12 or more visits over a 2 month period may be medically necessary. Refer to example protocol that follows.			
Acute		3 (HEP)	3 (HEP)
Subacute/Chronic		6 (HEP)	6 (HEP)
Fracture (post ORIF); (metatarsal, tarsal) Up to 12 visits over a 1 to 3 month period may be medically necessary.			
Acute		3 to 4 HEP	1 to 2 (HEP)
Chronic		4 to 6 HEP	1 to 2 (HEP)
Post ligament rupture (deltoid; collateral) Up to 40 visits over a 2 to 4 month period may be medically necessary.			
Acute		6 (HEP)	3+ (HEP)
Sub-acute		6 (HEP)	6+ (HEP)
Chronic		9 (HEP)	6+ (HEP)
Post tendon rupture, unspecified Up to 36 visits over a 2 to 4 month period may be medically necessary.			
Acute		6 (HEP)	3 (HEP)
Sub-acute		6 (HEP)	6 (HEP)
Chronic		9 (HEP)	6 (HEP)
Post tendon rupture, Achilles Up to 36 visits over a 2 to 4 month period may be medically necessary.			
Acute		6 (HEP)	6 (HEP)
Sub-acute		9 (HEP)	6 (HEP)
Chronic		12 (HEP)	6 (HEP)
Post tendon rupture, foot other than Achilles; Up to 36 visits over a 2 to 4 month period may be medically necessary.			
Acute		6 (HEP)	3 (HEP)
Sub-acute		6 (HEP)	6 (HEP)
Chronic		9 (HEP)	6 (HEP)
Hallux Rigidus/Limitus Up to 12 visits over a one-month period may be medically necessary.			
Chielectomy		6 (HEP)	3 (HEP)
Joint Implant		3 (HEP)	3 (HEP)

(a) Additional visits will be authorized *only* if initial visits demonstrate measurable objective and documented subjective progress, *or* for documented exacerbation during therapy. Additional visits are approved *only* on request and *only* if medically necessary. Recommendations for additional visits are an approximation of those required when complications are present and/or the patient has co-morbid conditions that slow progress in therapy (e.g., obesity, diabetes, frail) – either fewer or more visits may be required for a given individual. Additional visits will *not* be authorized retrospectively, and approved on a case-by-case basis.

A home exercise program (HEP), individually prescribed, is central to the care of most patients who have disorders of an extremity. The teaching for this program should be started on the first day of therapy and continue throughout the formal therapy program with a planned transition. One or two of the approved initial visits should be used for follow-up to assess and redirect the home program activities.