Physical Therapy and Chiropractic Guideline Methodology

Physical Therapy Guidelines

Physical Therapy Guidelines include recommended frequency and PT visits duration. Only appropriate conditions have physical therapy guidelines. These guidelines provide evidence-based benchmarks for the number of visits with a physical or occupational therapist and the period during which these visits take place. (Note: These guidelines do not include work hardening programs.) The physical therapy guidelines do not describe the type of therapy required, and the number of visits does not include physical therapy performed by the patient in their own home or work site, after proper training from a clinician. Unless noted otherwise, the visits indicated are for outpatient physical therapy, and the physical therapist's judgment is always a consideration in determining the appropriate frequency and duration of treatment. The physical therapy guidelines are supported by relevant medical literature and actual experience data, combined with consensus review by experts. The most important data sources are the high-quality medical studies that are referenced in the treatment guideline “Physical Therapy.” For clinical trials that show effectiveness for these therapies, the number of visits required to achieve this outcome is identified in each study and combined with the same information from other successful studies to arrive at the benchmark number of visits in ODG.

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline:

1. Over time, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency;
2. The exclusive use of "passive care" (e.g., palliative modalities) is not recommended;
3. Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program;
4. Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end;
5. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); and
6. When treatment duration and/or number of visits exceeds the guideline recommendation, exceptional factors should be noted.

Generally, there should be no more than 4 modalities/procedural units in total per visit, allowing the PT visit to focus on treatments that have shown evidence of functional improvement and limiting the total length of the visit to 45-60 minutes, unless additional circumstances require an extended length of treatment. Treatment times per session may vary based upon the patient's

medical presentation but typically may be 45-60 minutes to provide full, optimal care to the patient. Additional time may be required for the more complex and slow-to-respond patients. While an average of 3 or 4 modalities/procedural units per visit reflect a typical visit, this is not intended to limit or cap the number of units that are medically necessary for a patient (for example, in unusual cases where co-morbidities involve completely separate body domains), but documentation should support any average that exceeds 4 units per visit. These additional units should be reviewed for medical necessity and then authorized if determined to be medically appropriate for the individual injured worker.

As described above, users should refer to the treatment guidelines for more detail and for recommendations about specific treatments and modalities, along with supporting links to the highest quality relevant medical studies, which have been summarized and rated. In these treatment guidelines, different types of treatments are addressed that can be supported by the medical evidence, and they also identify the maximum number of visits that can be justified by the evidence; however, this does not mean that a provider should perform every possible treatment that may be recommended (actually, this would be highly unlikely, since the treatments span multiple specialties), or always deliver the maximum number of visits, without taking into account what was needed to cure the patient in a particular case. Furthermore, duplication of services is not considered medically necessary. While the recommendations for number of visits are guidelines and are not meant to be absolute caps for every case, they are also not meant to be a minimum requirement on each case (i.e., they are not an “entitlement”). Any provider doing this is not using the guidelines correctly, and provider profiling would flag these individuals as outliers. This applies to all types of treatment, not just physical therapy.

Furthermore, flexibility is especially important in the time frame recommendations. Generally, the number of weeks recommended should fall within a relatively cohesive time, between the dates of the first and last visits, but this period should not restrict additional recommended treatments that come later, for example due to scheduling issues or necessary follow-up compliance with a home-based program.

When there are co-morbidities, the same principles should apply as in the guidelines for return-to-work. In estimating the maximum number of treatment visits for workers with multiple diagnoses, users should use the number from the diagnosis with the longest number of visits. This assumes that whatever separate therapy, if any, that the lesser diagnosis requires can be done during the same visits that address the more serious problem. If there are reasons why these therapies cannot be concurrent, documentation should support medical necessity. For example, in unusual cases where co-morbidities involve separate body domains, requiring separate treatments that would be difficult to combine, either additional visits or additional time for a visit may be justified. [For this discussion, we would assume that there are three body domains: (1) spine and pelvis; (2) upper extremities and hands; and (3) lower extremities and feet.] Of course, each billed treatment should require one-on-one patient contact with the licensed therapist and not include modalities/exercises that the patient has learned to do on their own without supervision, and there should also be some economies of scale such that the involvement of two body domains should not require either a doubling of the number of visits or a doubling of the modalities (or time) per visit. Also see Multiple incidences of disability duration

below for recommendations regarding the number of treatment visits, for example, physical therapy, in these situations. And physical therapy visits post-surgery should be considered separately from visits to administer conservative treatment in an attempt to avoid surgery.

Multiple incidences of disability duration: When managing multiple incidences of disability duration for the same worker on a prospective basis, users should consider each one separately when creating return-to-work expectations using the "Best Practice" Guidelines. The disability duration data used to derive the pathways in the Return-to-Work "Best Practice" Guidelines is based on single incidences of missed work because that is the only way to isolate the specific factors affecting return-to-work in each of the pathways. (On the other hand, when benchmarking claims on a retrospective basis, users should be aware that the RTW claims data reflected in the average values or charts of claims data by decile include all instances of absence for each claim.) And, as with all disability durations in ODG, the length of disability is calculated by taking the return-to-work date minus the last day of work less one day. When using durations in the "Best Practice" Guidelines to manage a specific worker's absence on a prospective basis, the expected disability duration should generally "reset to zero" if the worker has returned to work for a period, but then misses work again at a later time. Furthermore, because of the potential for abuse from multiple incidences of absence, users should "reset" the duration only for the second instance of absence for the same condition within a year (not the third, fourth, etc.), and only if the time during which the worker returned to work is significant, i.e., it exceeds the disability duration that preceded it. Specific absences that exceed these guidelines will need to be reviewed on a case-by-case basis. The return-to-work period need not be job specific, so it may be regular work impacted by the medical condition, or either regular work or modified duty (where the condition should have a limited effect). In addition, please note that disability duration pathways for surgery are calculated from the date of surgery and not from the last day of work. These general principles should also apply to recommendations regarding the number of treatment visits, for example, physical therapy, even though these visits may not coincide with an absence from work. In general, a second set of physical therapy visits after a substantial time back at work may represent a recurrence of the original condition that might allow another series of physical therapy visits. Without a disability duration to trigger this reset, the "substantial time back at work" might be considered anything greater than the average number of days for that condition. And, physical therapy visits post-surgery should be considered separately from visits to administer conservative treatment in an attempt to avoid surgery. Again, the disability duration data in ODG that are used for retrospective benchmarking (rather than prospective claim management), for example, the Average values or the RTW Claims Data, include all incidences of disability duration for a single claim with that primary diagnosis over the previous year.

Physical medicine treatment (including PT, OT and chiropractic care) should be an option when the following apply: there is evidence of a musculoskeletal or neurologic condition that is associated with functional limitations; the functional limitations are likely to respond to skilled physical medicine treatment (e.g., fusion of an ankle would result in loss of ROM, but this loss would not respond to PT, though there may be PT needs for gait training, etc.); care is active and includes a home exercise program; and the patient is compliant with care and makes significant functional gains with treatment.

Chiropractic Guidelines

Chiropractic Guidelines are next, showing recommended frequency and duration of chiropractic care. These guidelines provide evidence-based benchmarks for the number of visits with a chiropractor and the period during which these visits should take place. The chiropractic guidelines are supported by relevant medical literature and actual experience data, combined with consensus review by experts. The most important data sources are the high-quality medical studies cited in the treatment guideline "Manipulation." For clinical trials that show effectiveness for manipulation, the number of visits required to achieve this outcome is identified in each study and combined with the same information from other successful studies to arrive at the benchmark number of visits in ODG. Another major source was the "Mercy Guidelines," the consensus document created by the American Chiropractic Association in conjunction with the Congress of State Chiropractic Associations, entitled *Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference.* Many of the general philosophies described above under "Physical Therapy Guidelines" should also apply to the chiropractic guidelines. More specifically, in addition to a "six-visit clinical trial," every six visits thereafter, the treating physical or occupational therapist/chiropractor should validate improvement in function as it relates to the patient's essential job functions, hours working, health-related quality of life indicators (e.g., Oswestry Disability Index) or a standard pain scale for treatment to continue. Pain reduction should be accompanied by improved function and/or reduced medication use. For other general guidelines that may apply to chiropractic care, see also Physical Therapy Guidelines.