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2025 Physical Medicine & Rehabilitation (PM&R) Home Health Care (HHC) and Outpatient (OP) Physical Therapy (PT) • Occupational Therapy (OT) • Speech Language Pathology (SLP) • Endoscopic Swallowing Studies

Physical Medicine and Rehabilitation

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2025 Home Healthcare Physical Medicine & Rehabilitation Guidelines

Physical Medicine & Rehabilitation

Last Review Date: 12/05/2024
Previous Review Date: 01/15/2024
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Home Healthcare Contraindications or Exclusions for PT, OT or SLP

Home healthcare may be contraindicated or excluded for **ANY** of the following:

1. Individual's care may **NOT** be safely done in the home due to **ANY** of the following:
    a. Physical environment is unsafe or inadequate for needed care.
    b. Support person is needed and is **NOT** consistently available to provide care.
    c. Individual's care needs exceed ability or capacity of self and support caregivers.
2. Cognitive (eg, poor recall, disorientation) or physical status (eg, activity intolerance, complication) prevents safe effective program participation.
3. Infection signs (eg, fever, chills, swelling) are present.
4. Neurological signs (eg, paralysis, visual changes, severe ongoing headache) that are new are present.

Occupational Therapy Home Healthcare

Adult Home Healthcare: Occupational Therapy (OT) Initial Evaluation

Adult Guideline

A home healthcare (HHC) occupational therapy (OT) initial evaluation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Individual is homebound with functional impairments making it a considerable taxing effort to leave home **OR** is ordered by provider to stay at home (eg, isolation).
2. Individual was seen by ordering provider within the past 90 days *before* the start-of-care **OR** is scheduled to be seen by the ordering provider within 30 days *after* the start-of-care.

3. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
4. Individual/support caregiver requires education, training and teach-back for OT care.
5. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
6. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training
    b. Adaptive modifications (eg, grab bars, reachers)
    c. Cardiac, neurological or pulmonary rehabilitation program
    d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)
    e. Lymphedema management
    f. Environmental modifications (eg, ramps, hand-rails)
    g. Equipment use and care (eg, walker, wheelchair)
    h. Exercise program with progression appropriate to ability and tolerance.
    i. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training
    j. Occupational training/re-training
    k. Pain management
    l. Peri-operative procedure rehabilitation (before/after invasive procedure)
    m. Safety techniques (eg, fall precautions, home safety)
    n. Therapeutic modality application and evaluation
7. OT treatment goals with support caregiver assistance if needed, includes **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Condition/disease self or supportive care are safely performed independently.

f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

g. Functional ability is improved to maximum independence.

h. Independent activities of daily living (IADLs) are safely performed independently.

i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [8] [9] [10] [17] [2] [26] [15] [19] [3] [21] [22] [3] [4] [6] [7] [3] [20] [6] [2] [5] [28] [18] [25]

Adult Home Healthcare: Occupational Therapy (OT) Continued Visits

Adult Guideline

Home healthcare (HHC) occupational therapy (OT) rehabilitation for the same episode-of-care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Individual is homebound with functional impairments making it a considerable taxing effort to leave home **OR** is ordered by provider to stay at home (eg, isolation).
2. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
3. Individual/support caregiver continue to require education, training and/or teach-back for OT care.
4. Individual is actively participating in and following-up with treatment.
5. Individual is (reasonably) expected a return to self/supported independence.
6. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using

a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).

7. OT treatment goals with support caregiver assistance if needed, include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.
    d. Balance is optimal.
    e. Cardiac, neurological or pulmonary rehabilitation program safely performed independently.
    f. Condition/disease self or supportive care are safely performed independently.
    g. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    h. Functional ability is improved to maximum independence.
    i. Independent activities of daily living (IADLs) are safely performed independently.
    j. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.
    k. Pain is managed optimally.
    l. Prosthesis/orthotic use and care are safely performed independently.
    m. Splint/brace use and care are safely performed independently.
    n. Strength, endurance and range-of-motion (ROM) are optimal.
    o. Therapeutic exercises safely performed independently.

References: [8] [9] [10] [17] [2]

LCD 34560
See also, **LCD 34560**: Home Health Occupational Therapy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Pediatric Home Healthcare: Occupational Therapy (OT) Initial Evaluation

Pediatrics Guideline

A home healthcare (HHC) occupational therapy (OT) initial evaluation with care plan implementation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Child is homebound when the effort to leave home is considerably taxing or unsafe due to the child's clinical status **OR** when the provider order's the child to stay at home (eg, isolation).
2. Individual was seen by ordering provider within the past 90 days *before* the start-of-care **OR** is scheduled to be seen by the ordering provider within 30 days *after* the start-of-care.
3. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
4. Child has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for age, developmental level and clinical status
5. Individual/support caregiver requires education, training and teach-back for OT care.
6. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training
    b. Adaptive modifications (eg, grab bars, reachers)
    c. Cardiac, neurological or pulmonary rehabilitation program
    d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)
    e. Developmental delay rehabilitation
    f. Lymphedema management
    g. Environmental modifications (eg, ramps, hand-rails)
    h. Equipment use and care (eg, walker, wheelchair)
    i. Exercise program with progression appropriate to ability and tolerance.
    j. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training

k. Occupational training/re-training

l. Pain management

m. Peri-operative procedure rehabilitation (before/after invasive procedure)

n. Safety techniques (eg, fall precautions, home safety)

o. Therapeutic modality application and evaluation

7. OT treatment goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:

a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.

b. Adaptive equipment use and care are safely performed independently.

c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Cardiac, neurological or pulmonary rehabilitation program safely performed independently.

f. Condition/disease self or supportive care are safely performed independently.

g. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

h. Functional ability is improved to maximum independence.

i. Independent activities of daily living (IADLs) are safely performed independently.

j. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

k. Pain is managed optimally.

l. Prosthesis/orthotic use and care are safely performed independently.

m. Splint/brace use and care are safely performed independently.

n. Strength, endurance and range-of-motion (ROM) are optimal.

o. Therapeutic exercises safely performed independently.

References: [2] [15]

Pediatric Home Healthcare: Occupational Therapy (OT) Continued Visits

Pediatric Guideline

Home healthcare (HHC) occupational therapy (OT) rehabilitation for the same episode-of-care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Child is homebound when the effort to leave home is considerably taxing or unsafe due to the child's clinical status **OR** when the provider order's the child to stay at home (eg, isolation).
2. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
3. Individual/support caregiver is actively participating in and following-up with treatment.
4. Individual/support caregiver continue to require education, training and/or teach-back for OT care.
5. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
6. OT Treatment goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.
    d. Balance is optimal.
    e. Cardiac, neurological or pulmonary rehabilitation program safely performed independently.
    f. Condition/disease self or supportive care are safely performed independently.
    g. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    h. Functional ability is improved to maximum independence.

i. Independent activities of daily living (IADLs) are safely performed independently.

j. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

k. Pain is managed optimally.

l. Prosthesis/orthotic use and care are safely performed independently.

m. Splint/brace use and care are safely performed independently.

n. Strength, endurance and range-of-motion (ROM) are optimal.

o. Therapeutic exercises safely performed independently.

References: [2]

Occupational Therapy (OT) Home Healthcare Procedure Codes

Table 1. Home Healthcare Occupational Therapy (OT) Associated Procedure Codes

CODE	DESCRIPTION
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
S9129	Occupational therapy, in the home, per diem
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes

Occupational Therapy (OT) Home Healthcare Summary of Changes

Occupational Therapy (OT) Home Healthcare guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Physical Therapy Home Healthcare

Adult Home Healthcare: Physical Therapy (PT) Initial Evaluation

Adult Guideline

A home healthcare (HHC) physical therapy (PT) initial evaluation with care plan implementation for rehabilitation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Individual is homebound with functional impairments making it a considerable taxing effort to leave home **OR** is ordered by provider to stay at home (eg, isolation).
2. Individual was seen by ordering provider within the past 90 days *before* the start-of-care **OR** is scheduled to be seen by the ordering provider within 30 days *after* the start-of-care.
3. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
4. Individual/support caregiver requires education, training and teach-back for PT care.
5. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
6. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training
    b. Adaptive modifications (eg, grab bars, reachers)
    c. Cardiac, neurological or pulmonary rehabilitation program
    d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)
    e. Lymphedema management
    f. Environmental modifications (eg, ramps, hand-rails)
    g. Equipment use and care (eg, walker, wheelchair)
    h. Exercise program with progression appropriate to ability and tolerance.
    i. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training

j. Pain management

k. Peri-operative procedure rehabilitation (before/after invasive procedure)

l. Safety techniques (eg, fall precautions, home safety)

m. Therapeutic modality application and evaluation

7. PT goals with support caregiver assistance if needed, Include **ANY** of the following:

a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.

b. Adaptive equipment use and care are safely performed independently.

c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Condition/disease self or supportive care are safely performed independently.

f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

g. Functional ability is improved to maximum independence.

h. Independent activities of daily living (IADLs) are safely performed independently.

i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [8] [9] [10] [17] [15]

Adult Home Healthcare: Physical Therapy (PT) Continued Visits

Adult Guideline

Home healthcare (HHC) physical therapy (PT) rehabilitation for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Individual is homebound with functional impairments making it a considerable taxing effort to leave home **OR** is ordered by provider to stay at home (eg, isolation).

2. Individual/support caregiver continues to require education, training and teach-back for PT care.
3. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
4. Individual is actively participating in and following-up with treatment.
5. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
6. PT goals with support caregiver assistance if needed, include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.
    d. Balance is optimal.
    e. Cardiac, neurological or pulmonary rehabilitation program safely performed independently.
    f. Condition/disease self or supportive care are safely performed independently.
    g. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    h. Functional ability is improved to maximum independence.
    i. Independent activities of daily living (IADLs) are safely performed independently.
    j. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.
    k. Pain is managed optimally.
    l. Prosthesis/orthotic use and care are safely performed independently.
    m. Splint/brace use and care are safely performed independently.
    n. Strength, endurance and range-of-motion (ROM) are optimal.
    o. Therapeutic exercises safely performed independently.

References: [8] [9] [10] [17]

LCD 33942
See also, **LCD 33942**: Physical Therapy - Home Health at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 34564
See also, **LCD 34564**: Home Health Physical Therapy at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Pediatric Home Healthcare: Physical Therapy (PT) Initial Evaluation

Pediatrics Guideline

A home healthcare (HHC) physical therapy (PT) initial evaluation with care plan implementation for rehabilitation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
2. Child is homebound when the effort to leave home is considerably taxing or unsafe due to the child's clinical status **OR** when the provider order's the child to stay at home (eg, isolation).
3. Individual/support caregiver requires education, training and teach-back for PT care.
4. Individual was seen by ordering provider within the past 90 days *before* the start-of-care **OR** is scheduled to be seen by the ordering provider within 30 days *after* the start-of-care.
5. Child has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for age, developmental level and clinical status
6. Therapist's skills are needed to assess functional status, measure progression and create/modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training
    b. Adaptive modifications (eg, grab bars, reachers)

c. Cardiac, neurological or pulmonary rehabilitation program

d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)

e. Developmental delay rehabilitation

f. Lymphedema management

g. Environmental modifications (eg, ramps, hand-rails)

h. Equipment use and care (eg, walker, wheelchair)

i. Exercise program with progression appropriate to ability and tolerance.

j. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training

k. Pain management

l. Peri-operative procedure rehabilitation (before/after invasive procedure)

m. Safety techniques (eg, fall precautions, home safety)

n. Therapeutic modality application and evaluation

7. PT goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:

a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.

b. Adaptive equipment use and care are safely performed independently.

c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Cardiac, neurological or pulmonary rehabilitation program safely performed independently.

f. Condition/disease self or supportive care are safely performed independently.

g. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

h. Functional ability is improved to maximum independence.

i. Independent activities of daily living (IADLs) are safely performed independently.

j. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

k. Pain is managed optimally.

l. Prosthesis/orthotic use and care are safely performed independently.

m. Splint/brace use and care are safely performed independently.

n. Strength, endurance and range-of-motion (ROM) are optimal.

o. Therapeutic exercises safely performed independently.

References:[15]

Pediatric Home Healthcare: Physical Therapy (PT) Continued Visits

Pediatrics Guideline

Home healthcare (HHC) physical therapy (PT) rehabilitation for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Child is homebound when the effort to leave home is considerably taxing or unsafe due to the child's clinical status **OR** when the provider order's the child to stay at home (eg, isolation).
2. Individual/support caregiver continues to require education, training and teach-back for PT care.
3. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
4. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
5. Individual/support caregiver is actively participating in and following-up with treatment.
6. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
7. PT goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:

    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.

    b. Adaptive equipment use and care are safely performed independently.

c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Cardiac, neurological or pulmonary rehabilitation program safely performed independently.

f. Condition/disease self or supportive care are safely performed independently.

g. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

h. Functional ability is improved to maximum independence.

i. Independent activities of daily living (IADLs) are safely performed independently.

j. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

k. Pain is managed optimally.

l. Prosthesis/orthotic use and care are safely performed independently.

m. Splint/brace use and care are safely performed independently.

n. Strength, endurance and range-of-motion (ROM) are optimal.

o. Therapeutic exercises safely performed independently.

References: [15]

Physical Therapy (PT) Home Healthcare Procedure Codes

Table 1. Home Healthcare Physical Therapy (PT) Associated Procedure Codes

CODE	DESCRIPTION
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
S9131	Physical therapy; in the home, per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes

Physical Therapy (PT) Home Healthcare Summary of Changes

Physical Therapy (PT) Home Healthcare guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Speech Language Pathology Home Healthcare

Adult Home Healthcare: Speech Language Pathology (SLP) Initial Evaluation

Adult Guideline

NCD 170.3
See also, **NCD 170.3**: Speech Language Pathology Services for the Treatment of Dysphagia. at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

A home healthcare (HHC) speech language pathology (SLP) initial evaluation with care plan implementation for rehabilitation is medically appropriate when the documentation demonstrates**ALL** of the following:

1. Individual is homebound with functional impairments making it a considerable taxing effort to leave home **OR** is ordered by provider to stay at home (eg, isolation).
2. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
3. Individual was seen by ordering provider within the past 90 days *before* the start-of-care **OR** is scheduled to be seen by the ordering provider within 30 days *after* the start-of-care.
4. Individual/support caregiver continues to require education, training and/or teach-back for SLP care.
5. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
6. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Adaptive modifications (eg, speech synthesizer, diet changes)
    b. Aphasia rehabilitation for oral/written comprehension, expression and/or word retrieval.
    c. Cognitive communication disorder rehabilitation
    d. Complication monitoring and care (eg, choking, malnutrition)
    e. Dietary modifications and/or advancement

f. Dysarthria rehabilitation
g. Dysphagia rehabilitation
h. Equipment use and care (eg, adaptive feeding equipment, oral appliances)
i. Exercise program with progression appropriate to ability and tolerance.
j. Functional ability loss management (eg, swallowing impairment and use of thickeners)
k. Fluency disorder rehabilitation
l. Pain management
m. Peri-operative procedure rehabilitation (before/after invasive procedure)
n. Safety techniques (eg, airway protection, aspiration precautions)
o. Vocal disorder rehabilitation

7. SLP goals with support of caregiver if needed, include **ANY** of the following:
   a. Adaptive equipment use and care are safely performed independently.
   b. Condition/disease self or supportive care are safely performed independently.
   c. Diet advancement safely to optimal functional level.
   d. Functional ability is improved to maximum independence.
   e. Independent activities of daily living (IADLs) are safely performed independently.
   f. Motor strength (laryngeal, oral, pharyngeal), endurance and range-of-motion (ROM) are improved to maximum independence.
   g. Pain is managed optimally.
   h. Safety measures are identified, implemented and training demonstrated to maximum independence.
   i. Swallowing is improved to maximum functional level.
   j. Therapeutic exercises are understood and safely performed independently.

References: [8] [9] [10] [17] [2][15] [1] [3]

Adult Home Healthcare: Speech Language Pathology (SLP) Continued Visits

Adult Guideline

NCD 170.3
See also, **NCD 170.3**: Speech Language Pathology Services for the Treatment of Dysphagia. at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Home healthcare (HHC) speech language pathology (SLP) rehabilitation for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Individual is homebound with functional impairments making it a considerable taxing effort to leave home **OR** is ordered by provider to stay at home (eg, isolation).
2. Individual/support caregiver continues to require education, training and/or teach-back for SLP care.
3. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
4. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
5. Individual is actively participating in and following-up with treatment.
6. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
7. SLP goals with support of caregiver if needed, include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Condition/disease self or supportive care are safely performed independently.
    d. Functional ability is improved to maximum independence.

e. Independent activities of daily living (IADLs) are safely performed independently.

f. Pain is managed optimally.

g. Prosthesis use and care are safely performed independently.

h. Therapeutic exercises safely performed independently.

References: [8] [9] [10] [17]

LCD 34563
See also, **LCD 34563**: Home Health Speech-Language Pathology at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Pediatric Home Healthcare: Speech Language Pathology (SLP) Initial Evaluation

Pediatrics Guideline

A home healthcare (HHC) speech language pathology (SLP) initial evaluation with care plan implementation for rehabilitation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Child is homebound when the effort to leave home is considerably taxing or unsafe due to the child's clinical status **OR** when the provider order's the child to stay at home (eg, isolation).
2. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
3. Individual was seen by ordering provider within the past 90 days *before* the start-of-care **OR** is scheduled to be seen by the ordering provider within 30 days *after* the start-of-care.
4. Child has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for age, developmental level and clinical status
5. Individual/support caregiver continues to require education, training and/or teach-back for SLP care.
6. Therapist's skills are needed to assess functional status, measure progression and create/modify the plan of care for **ANY** of the following:
    a. Adaptive modifications (eg, speech synthesizer, diet changes)

b. Aphasia rehabilitation for oral/written comprehension, expression and/or word retrieval.
c. Cognitive communication disorder rehabilitation
d. Complication monitoring and care (eg, choking, malnutrition)
e. Developmental speech/language disorder rehabilitation
f. Dietary modifications and/or advancement
g. Dysarthria rehabilitation
h. Dysphagia rehabilitation
i. Equipment use and care (eg, adaptive feeding equipment, oral appliances)
j. Exercise program with progression appropriate to ability and tolerance.
k. Functional ability loss management (eg, swallowing impairment and use of thickeners)
l. Fluency disorder rehabilitation
m. Infant oral feeding/breast feeding training
n. Pain management
o. Peri-operative procedure rehabilitation (before/after invasive procedure)
p. Safety techniques (eg, airway protection, aspiration precautions)
q. Vocal disorder rehabilitation

7. SLP goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:
   a. Adaptive equipment use and care are safely performed independently.
   b. Condition/disease self or supportive care are safely performed independently.
   c. Diet advancement safely to optimal functional level.
   d. Functional ability is improved to maximum independence.
   e. Independent activities of daily living (IADLs) are safely performed independently.
   f. Infant is feeding successfully and gaining weight appropriately.
   g. Motor strength (laryngeal, oral, pharyngeal), endurance and range-of-motion (ROM) are improved to maximum independence.
   h. Pain is managed optimally.
   i. Safety measures are identified, implemented and training demonstrated to maximum independence.

j. Swallowing is improved to maximum functional level.

k. Therapeutic exercises are understood and safely performed independently.

References: [3] [1]

Pediatric Home Healthcare: Speech Language Pathology (SLP) Continued Visits

Pediatric Guideline

Home healthcare (HHC) speech language pathology (SLP) rehabilitation for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Child is homebound when the effort to leave home is considerably taxing or unsafe due to the child's clinical status **OR** when the provider order's the child to stay at home (eg, isolation).
2. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
3. Individual/support caregiver continues to require education, training and/or teach-back for SLP care.
4. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
5. Individual/support caregiver is actively participating in and following-up with treatment.
6. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
7. SLP goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Condition/disease self or supportive care are safely performed independently.
    d. Functional ability is improved to maximum independence.

e. Infant is feeding successfully and gaining weight appropriately.

f. Improved expressive and/or receptive language skills.

g. Pain is managed optimally.

h. Prosthesis use and care are safely performed independently.

i. Therapeutic exercises safely performed independently.

References:[1] [3]

Speech Language Pathology (SLP) Home Healthcare Procedure Codes

Table 1. Home Healthcare Speech Language Pathology (SLP) Associated Procedure Codes

CODE	DESCRIPTION
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
S9128	Speech therapy, in the home, per diem
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Speech Language Pathology (SLP) Home Healthcare Summary of Changes

Speech Language Pathology (SLP) Home Healthcare guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Added receptive/expressive language skills to pediatric continued visit guideline per current research.

Therapeutic Modalities Procedure Codes

Table 1. Therapeutic Modalities Associated Procedure Codes

CODE	DESCRIPTION
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)

Occupational Therapy (OT) Home Healthcare Summary of Changes

Occupational Therapy (OT) Home Healthcare guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Physical Therapy (PT) Home Healthcare Summary of Changes

Physical Therapy (PT) Home Healthcare guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Speech Language Pathology (SLP) Home Healthcare Summary of Changes

Speech Language Pathology (SLP) Home Healthcare guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Added receptive/expressive language skills to pediatric continued visit guideline per current research.

Physical Medicine & Rehabilitation Definitions

Activities of daily living (ADLs) are tasks that people perform to stay healthy and alive. They include eating, dressing, using the toilet, getting in and out of bed, bathing or showering, and walking.

Adaptive equipment refers to devices designed to assist individuals with disabilities in performing activities of daily living and improving mobility, thereby enhancing independence and reducing caregiver burden.

Aphasia rehabilitation, or speech and language therapy, helps people with aphasia improve their communication skills. The goals of aphasia rehabilitation include: restoring lost language abilities, strengthening existing communication skills, teaching compensatory strategies and using aids, and finding alternative ways to communicate.

Dietary modifications can refer to changes made to food preparation, processing, or consumption to increase micronutrient bioavailability or reduce deficiencies. They can also refer to changes made to your diet to improve your health, such as: eating a variety of nutritious foods, reducing salt intake, cutting back on bad fats, drinking more water, eating more fiber.

Dysarthria rehabilitation can include a variety of treatments and activities, depending on the type and severity of the condition and its cause

Dysphagia rehabilitation is a combination of approaches to improve or compensate for swallowing disorders. Treatments can include: rehabilitative exercises: these exercises are designed to improve swallowing function over time by strengthening muscles or using different muscles to compensate for damaged ones. Some examples include the Shaker exercise, expiratory muscle strength training, and tongue pressure resistance training. Compensatory techniques are techniques that alter swallowing to compensate for deficits that can't be rehabilitated yet. For example, a head rotation can be used to direct food toward the side of the throat during swallowing. Diet modifications can include thickened liquids or modified food textures. Early identification: Screening or assessment can help identify swallowing difficulties early.

Environmental modifications, or E-Mods, are physical changes to a home or vehicle that help people be more independent, safer, and healthier. They can include installing ramps, grab bars, and railings, widening doorways, modifying bathrooms, installing specialized electrical and plumbing systems, adapting lighting or desk height, adding roll-in showers and lifts, installing automatic or manual door openers and doorbells, and adapting cabinets and shelving.

Expressive vocabulary refers to the aspect of language function that involves the production and communication of words and language. Expressive vocabulary encompasses the ability to name objects, describe actions, and formulate sentences, which is essential for effective communication. It is assessed through various neuropsychological and developmental measures, such as the Boston Naming Test and expressive tasks in the WAIS-IV Vocabulary Subtest. Expressive vocabulary development is crucial in early childhood, as it enables children to articulate

thoughts, participate in conversations, and influence their environment. Deficits in expressive vocabulary can manifest as difficulties in word retrieval, speech production, and constructing grammatically correct sentences. Expressive vocabulary skills are linked to broader cognitive and academic abilities, influencing a child's learning and social interactions.

Functional ability is a person's capacity to perform activities and tasks that are normal for them, and is a key factor in determining their quality of life. It's a combination of a person's intrinsic capacity and environmental factors, and how they interact.

Functional impairment (FI) is a term used to describe limitations in a person's ability to perform everyday tasks, or to function in social and occupational settings. It can be caused by a number of factors, including congenital or acquired. FI can be present from birth or develop as a result of injury or illness. mental or physical. FI can affect a person's mental functioning or body structure, such as vision, hearing, or movement. Developmental FI can affect language development or growth.

Lymphedema management is the process of reducing swelling and preventing complications in the arms and legs caused by lymphedema.

Mental ability is the capacity to learn, retain, or process information, or the ability to understand the significance of one's behavior.

Pain management is an aspect of medicine and health care involving relief of pain in various dimensions, from acute and simple to chronic and challenging.

Physical Therapy the treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery.

Range of motion (ROM) is the degree of movement a joint can make, from full extension to full flexion, or bending. It's a measurement of flexibility that involves the muscles, tendons, ligaments, bones, and joints.

Receptive vocabulary refers to the ability to understand words and language. It involves the comprehension of spoken or written language without the need to actively produce it. Receptive vocabulary is crucial for effective communication and understanding in both everyday and academic contexts. The development of receptive vocabulary can be influenced by various educational methods, including mobile-assisted learning, which has shown to significantly improve this aspect of vocabulary knowledge. Understanding receptive vocabulary is essential for diagnosing and addressing language-related challenges in clinical settings.

Safety techniques are tools and practices that help prevent accidents and injuries

Therapeutic exercise is a series of physical activities and movements that are prescribed to help improve a patient's health and well-being. It's often used as part of physical therapy to help treat injuries and chronic conditions.

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2025 Endoscopic Swallowing Study

Physical Medicine & Rehabilitation

Last Review Date: 03/21/2025
Previous Review Date: 03/20/2024
Guideline Initiated: 03/20/2024

Video Fluoroscopy Contraindications or Exclusions

Video fluoroscopy is contraindicated if the documentation demonstrates **ANY** of the following:

- Aspiration risks to contrast, food or liquid are present.
- Positioning for fluoroscopy is clinically undesirable (eg, bedridden, contractures, ventilator).

Reference: [7]

Endoscopic Swallowing Study Contraindications or Exclusions

An endoscopic swallowing study is contraindicated or excluded if the documentation demonstrates **ANY** of the following:

- Bleeding disorders that are severe.
- Inability mentally/physically to cooperate with the test (eg, severe agitation, movement disorders complicate)
- Nasal passage(s) are obstructed.
- Trauma to the nasal cavity or nearby structures that is recent.

References: [7]

Endoscopic Swallowing Study

Endoscopic Swallowing Study Guideline

An endoscopic swallowing evaluation (or Flexible Endoscopic Evaluation of Swallowing [FEES]) is medically appropriate when the documentation demonstrates **ANY** of the following:

- Dysphagia is severe with absent/weak swallow reflex and/or unable to tolerate aspiration due to clinical status (eg, brainstem stroke, prolonged tube feeding, poor pulmonary/ immunological status).
- Hyper-nasality is suspected (a velum function evaluation).
- Larynx competence evaluation post-intubation or post-surgery where the recurrent laryngeal nerve was vulnerable (eg, coronary artery bypass grafting, carotid endarterectomy).
- Nasal regurgitation is suspected.
- Post-therapeutic swallowing treatment for clinical status evaluation and related care planning update.
- Swallowing evaluation needs to be done over a meal (eg, to assess fatigue-related dysphagia).
- Swallowing maneuver trials to assess swallowing of several foods in a variety of consistencies.
- Video fluoroscopy is contraindicated (*see the Video Fluoroscopy Contraindications section for more information*).
- Video fluoroscopic swallowing study demonstrated pharyngeal dysphagia that needs further evaluation for treatment planning.

References: [1] [2] [3] [4] [5]

Swallowing Study Endoscopy Procedure Codes

Table 1. Swallowing Study Endoscopy Associated Procedure Codes

CODE	DESCRIPTION
92612	Flexible endoscopic evaluation of swallowing by cine or video recording;
92613	Flexible endoscopic evaluation of swallowing by cine or video recording; interpretation and report only
92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording;
92615	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only
92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;
92617	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; interpretation and report only

Swallowing Study Endoscopy Summary of Changes

Swallowing Study Endoscopy guideline from 2024 to 2025 had the following changes:
* Citation updated per the evidence.
* Evidence reviewed and indications remained the same.

Swallowing Study Endoscopy Definitions

Dysphagia is defined as difficulty or inability to swallow. It involves an impairment in the normal process of moving food or liquid from the mouth through the throat (pharynx) and into the esophagus. Dysphagia can affect individuals of all ages and can be caused by a variety of factors, including neurological disorders, structural abnormalities, and muscle weakness. It can range in severity from mild discomfort to an inability to swallow anything at all.

An **Endoscopic Swallowing Evaluation**, also known as a fiberoptic endoscopic evaluation of swallowing (FEES), is a procedure that assesses how well someone swallows. It's used to diagnose swallowing impairments and help determine the best treatments.

Hypernasality is a speech disorder that occurs when too much sound vibrates in the nose while speaking. It can make someone sound like they are talking through their nose

Nasal regurgitation is when food or liquid comes back up into your nose after swallowing. It can happen when the nasopharynx, the part of your throat that connects to your nose, doesn't close properly.

A **swallowing evaluation** is a collection of tests and procedures that assess how well someone swallows. It can help identify swallowing difficulties, also known as dysphagia

A **swallowing maneuver** is a voluntary technique that changes how you swallow to move food or liquid safely to your esophagus. Clinicians use swallowing maneuvers to treat swallowing disorders.

A **videofluoroscopic swallowing study (VFSS)** is an X-ray exam that evaluates swallowing function. It's also known as a modified barium swallow (MBS).

Swallowing Study Endoscopy References

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Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.

CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.

In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

For Internal Use Only:

11248 11249 11253 11282 11325 11328 11333 11349 11350 11351 11352 11354 11355 11356 11358 11359 11360 11361 11362 11365 11366 11367 11368 11369 11370 11374 11375 11394 11395 11396 11565

2025 Outpatient Physical Medicine & Rehabilitation Guidelines

Physical Medicine & Rehabilitation

Last Review Date: 12/05/2024

Previous Review Date: 01/15/2024

Guideline Initiated: 01/15/2024

Outpatient Contraindications or Exclusions for PT, OT or SLP

Outpatient (OP) PT, OT and SLP may be contraindicated or excluded for **ANY** of the following:

1. Individual's care needs exceed ability or capacity for outpatient therapy participation.
2. Individual cannot reliably participate in an outpatient therapy program.
3. Individual's care needs exceed ability or capacity of self and support caregivers.
4. Cognitive (eg, poor recall, disorientation) or physical status (eg, activity intolerance, complication) prevents safe effective program participation.
5. Fracture or dislocation signs (eg, severe pain, functional loss) are present.
6. Infection signs (eg, fever, chills, swelling) are present.
7. Neurological signs (eg, paralysis, visual changes, severe ongoing headache) that are new are present.

Outpatient (OP) Occupational Therapy (OT)

Adult Occupational Therapy (OT) Outpatient Initial Evaluation

Adult Guideline

An outpatient (OP) occupational therapy (OT) initial evaluation with care plan implementation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Individual has ability, cognitively (eg, mental ability, memory) **AND** physically (eg, no contraindications, clinically stable), to participate in therapy program.
2. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
3. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training

b. Adaptive modifications (eg, grab bars, reachers)

c. Cardiac, neurological or pulmonary rehabilitation program

d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)

e. Developmental delay rehabilitation

f. Lymphedema management

g. Environmental modifications (eg, ramps, hand-rails)

h. Equipment use and care (eg, walker, wheelchair)

i. Exercise program with progression appropriate to ability and tolerance.

j. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training

k. Occupational training/re-training

l. Pain management

m. Peri-operative procedure rehabilitation (before/after invasive procedure)

n. Safety techniques (eg, fall precautions, home safety)

o. Therapeutic modality application and evaluation

4. OT treatment goals include **ANY** of the following:

a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.

b. Adaptive equipment use and care are safely performed independently.

c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Condition/disease self or supportive care are safely performed independently.

f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

g. Functional ability is improved to maximum independence.

h. Independent activities of daily living (IADLs) are safely performed independently.

i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [2]

Adult Occupational Therapy (OT) Continued Outpatient Visits

Adult Guideline

Outpatient occupational therapy (OT) continued rehabilitation for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Individual is actively participating in and following-up with treatment.
2. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
3. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
4. OT treatment goals include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.
    d. Balance is optimal.
    e. Condition/disease self or supportive care are safely performed independently.
    f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    g. Functional ability is improved to maximum independence.
    h. Independent activities of daily living (IADLs) are safely performed independently.
    i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [2]

LCD 33631
See also, **LCD 33161**: Outpatient Physical and Occupational Therapy Services at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 34049
See also, **LCD 34049**: Outpatient Physical and Occupational Therapy Services at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Pediatric Occupational Therapy (OT) Outpatient Initial Evaluation

Pediatric Guideline

An outpatient (OP) occupational therapy (OT) initial evaluation with care plan implementation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
2. Child/support caregiver has capability to make measurable improvement toward therapy goals, in a reasonable timeframe for developmental and clinical status,
3. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training

b. Adaptive modifications (eg, grab bars, reachers)

c. Cardiac, neurological or pulmonary rehabilitation program

d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)

e. Developmental delay rehabilitation

f. Lymphedema management

g. Environmental modifications (eg, ramps, hand-rails)

h. Equipment use and care (eg, walker, wheelchair)

i. Exercise program with progression appropriate to ability and tolerance.

j. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training

k. Occupational training/re-training

l. Pain management

m. Peri-operative procedure rehabilitation (before/after invasive procedure)

n. Safety techniques (eg, fall precautions, home safety)

o. Therapeutic modality application and evaluation

4. OT goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:

a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.

b. Adaptive equipment use and care are safely performed independently.

c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Condition/disease self or supportive care are safely performed independently.

f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

g. Functional ability is improved to maximum independence.

h. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

i. Pain is managed optimally.

j. Prosthesis/orthotic use and care are safely performed independently.

k. Splint/brace use and care are safely performed independently.

l. Strength, endurance and range-of-motion (ROM) are optimal.

m. Therapeutic exercises safely performed independently.

References: [2]

Pediatric Occupational Therapy (OT) Continued Outpatient Visits

Pediatric Guideline

Outpatient occupational therapy (OT) continued rehabilitation for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
2. Child/support caregiver has capability to make measurable improvement toward therapy goals, in a reasonable timeframe for developmental and clinical status,
3. Individual/support caregiver is actively participating in and following-up with treatment.
4. Individual/support caregiver demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. (*__NOTE__: Functional status should be measured using a validated tool, such as the Functional Improvement Measures (FIM)® tool.
5. OT goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.
    d. Balance is optimal.
    e. Condition/disease self or supportive care are safely performed independently.
    f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    g. Functional ability is improved to maximum independence.
    h. Independent activities of daily living (IADLs) are safely performed independently.

i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [2]

Occupational Therapy (OT) Outpatient Procedure Codes

Table 1. Outpatient Occupational Therapy (OT) Associated Procedure Codes

CODE	DESCRIPTION
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

Occupational Therapy (OT) Outpatient Summary of Changes

Occupational Therapy Outpatient guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Outpatient (OP) Physical Therapy (PT)

Adult Physical Therapy (PT) Outpatient Initial Evaluation

Adult Guideline

An outpatient (OP) physical therapy (PT) initial evaluation with care plan implementation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Individual has ability, cognitively (eg, mental ability, memory) **AND** physically (eg, no contraindications, clinically stable), to participate in therapy program.
2. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.

3. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training
    b. Adaptive modifications (eg, grab bars, reachers)
    c. Cardiac, neurological or pulmonary rehabilitation program
    d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)
    e. Developmental delay rehabilitation
    f. Lymphedema management
    g. Environmental modifications (eg, ramps, hand-rails)
    h. Equipment use and care (eg, walker, wheelchair)
    i. Exercise program with progression appropriate to ability and tolerance.
    j. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training
    k. Pain management
    l. Peri-operative procedure rehabilitation (before/after invasive procedure)
    m. Safety techniques (eg, fall precautions, home safety)
    n. Therapeutic modality application and evaluation
4. PT treatment goals include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.
    d. Balance is optimal.
    e. Condition/disease self or supportive care are safely performed independently.
    f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    g. Functional ability is improved to maximum independence.
    h. Independent activities of daily living (IADLs) are safely performed independently.
    i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [8] [17]

Adult Physical Therapy (PT) Continued Outpatient Visits

Adult Guideline

Outpatient physical therapy (PT) continued visits for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Individual is actively participating in and following-up with treatment.
2. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
3. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
4. PT treatment goals include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently.
    d. Balance is optimal.
    e. Condition/disease self or supportive care are safely performed independently.
    f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    g. Functional ability is improved to maximum independence.
    h. Independent activities of daily living (IADLs) are safely performed independently.
    i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [8] [17]

LCD 33631
See also, **LCD 33161**: Outpatient Physical and Occupational Therapy Services at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 34049
See also, **LCD 34049**: Outpatient Physical and Occupational Therapy Services at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Pediatric Physical Therapy (PT) Outpatient Initial Evaluation

Pediatric Guideline

An outpatient (OP) physical therapy (PT) initial evaluation with care plan implementation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
2. Child/support caregiver has capability to make measurable improvement toward therapy goals, in a reasonable timeframe for developmental and clinical status,
3. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Activities of daily living (ADL) (eg, bathing, dressing, toileting) safe/adaptive training
    b. Adaptive modifications (eg, grab bars, reachers)

c. Cardiac, neurological or pulmonary rehabilitation program

d. Complication monitoring and care (eg, new/increased edema or pain, change in functional ability and when/where to seek help for problems)

e. Developmental delay rehabilitation

f. Lymphedema management

g. Environmental modifications (eg, ramps, hand-rails)

h. Equipment use and care (eg, walker, wheelchair)

i. Exercise program with progression appropriate to ability and tolerance.

j. Independent activities of daily living (IADLs) (eg, banking, driving, shopping) safe/ adaptive training

k. Pain management

l. Peri-operative procedure rehabilitation (before/after invasive procedure)

m. Safety techniques (eg, fall precautions, home safety)

n. Therapeutic modality application and evaluation

4. PT goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:

a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.

b. Adaptive equipment use and care are safely performed independently.

c. Ambulation/gait/transfers are safely performed independently.

d. Balance is optimal.

e. Condition/disease self or supportive care are safely performed independently.

f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.

g. Functional ability is improved to maximum independence.

h. Independent activities of daily living (IADLs) are safely performed independently.

i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [4]

Pediatric Physical Therapy (PT) Continued Outpatient Visits

Pediatric Guideline

Outpatient physical therapy (PT) continued visits for the same episode of care (EOC) may continue when the documentation demonstrates **ALL** of the following:

1. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
2. Child/support caregiver has capability to make measurable improvement toward therapy goals, in a reasonable timeframe for developmental and clinical status,
3. Individual/support caregiver is actively participating in and following-up with treatment.
4. Individual/support caregiver demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. (*__NOTE__: Functional status should be measured using a validated tool, such as the Functional Improvement Measures (FIM)® tool.
5. PT goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.
    c. Ambulation/gait/transfers are safely performed independently..
    d. Balance is optimal.
    e. Condition/disease self or supportive care are safely performed independently.
    f. Equipment use and care (eg. walker, shower chair, raised toilet set) are safely performed independently.
    g. Functional ability is improved to maximum independence.
    h. Independent activities of daily living (IADLs) are safely performed independently.
    i. Mobilization techniques (eg, scar mobilization, patellar mobilization with total knee arthroplasty) safely performed independently.

j. Pain is managed optimally.

k. Prosthesis/orthotic use and care are safely performed independently.

l. Splint/brace use and care are safely performed independently.

m. Strength, endurance and range-of-motion (ROM) are optimal.

n. Therapeutic exercises safely performed independently.

References: [4]

Physical Therapy (PT) Outpatient Procedure Codes

Table 1. Outpatient Physical Therapy (PT) Associated Procedure Codes

CODE	DESCRIPTION
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.

Outpatient (OP) Physical Therapy (PT) Summary of Changes

Outpatient (OP) Physical Therapy (PT) guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Outpatient (OP) Speech Language Pathology (SLP)

Adult Speech Language Pathology (SLP) Outpatient Initial Evaluation

Adult Guideline

NCD 170.3
See also, **NCD 170.3**: Speech Language Pathology Services for the Treatment of Dysphagia. at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

An outpatient (OP) speech language pathology (SLP) initial evaluation with care plan implementation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Individual has ability, cognitively (eg, mental ability, memory) **AND** physically (eg, no contraindications, clinically stable), to participate in therapy program.
2. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
3. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Adaptive modifications (eg, speech synthesizer, diet changes)
    b. Aphasia rehabilitation for oral/written comprehension, expression and/or word retrieval.
    c. Cognitive communication disorder rehabilitation
    d. Complication monitoring and care (eg, choking, malnutrition)
    e. Developmental speech/language disorder rehabilitation
    f. Dietary modifications and/or advancement
    g. Dysarthria rehabilitation
    h. Dysphagia rehabilitation
    i. Equipment use and care (eg, adaptive feeding equipment, oral appliances)
    j. Exercise program with progression appropriate to ability and tolerance.
    k. Functional ability loss management (eg, swallowing impairment and use of thickeners)
    l. Fluency disorder rehabilitation
    m. Pain management
    n. Peri-operative procedure rehabilitation (before/after invasive procedure)
    o. Safety techniques (eg, airway protection, aspiration precautions)
    p. Vocal disorder rehabilitation
4. SLP treatment goals include **ANY** of the following:
    a. Adaptive equipment use and care are safely performed independently.
    b. Condition/disease self or supportive care are safely performed independently.
    c. Diet advancement safely to optimal functional level.
    d. Functional ability is improved to maximum independence.
    e. Independent activities of daily living (IADLs) are safely performed independently.

f. Motor strength (laryngeal, oral, pharyngeal), endurance and range-of-motion (ROM) are improved to maximum independence.

g. Pain is managed optimally.

h. Safety measures are identified, implemented and training demonstrated to maximum independence.

i. Swallowing is improved to maximum functional level.

j. Therapeutic exercises are understood and safely performed independently.

References: [4] [5]

Adult Speech Language Pathology (SLP) Continued Outpatient Visits

Adult Guideline

NCD 170.3
See also, **NCD 170.3**: Speech Language Pathology Services for the Treatment of Dysphagia. at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Outpatient speech language pathology (SLP) rehabilitation may continue for the same episode of care (EOC) when the documentation demonstrates **ALL** of the following:

1. Individual is actively participating in and following-up with treatment.
2. Individual has capability to make measurable improvement to self/assisted care, in a reasonable timeframe for clinical status.
3. Individual demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. ***NOTE**: improvements should be measured using a standardized outcome measures (eg, increased independence/decreased dependence, improved number of repetitions, ambulatory distance) and evaluation tools are part of the outpatient assessment forms (eg, OASIS, MDS).
4. SLP treatment goals include **ANY** of the following:
    a. Activities of daily living (ADLs) (eg, bathing, dressing, toileting) are safely performed independently.
    b. Adaptive equipment use and care are safely performed independently.

c. Condition/disease self or supportive care are safely performed independently.

d. Functional ability is improved to maximum independence.

e. Independent activities of daily living (IADLs) are safely performed independently.

f. Pain is managed optimally.

g. Prosthesis use and care are safely performed independently.

h. Therapeutic exercises safely performed independently.

References: [4] [5]

LCD 33580
See also, **LCD L33580**: Speech Language Pathology at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 34046
See also, **LCD 34046**: Speech Language Pathologyhujny at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

LCD 35070
See also, **LCD 35070**: Speech-Language Pathology (SLP) Services at https://www.cms.gov/medicare-coverage-database/search.aspx *if applicable to individual's healthplan membership*.

Pediatric Speech Language Pathology (SLP) Outpatient Initial Evaluation

Pediatric Guideline

An outpatient (OP) speech language pathology (SLP) initial evaluation with care plan implementation is medically appropriate when the documentation demonstrates **ALL** of the following:

1. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.

2. Child/support caregiver has capability to make measurable improvement toward therapy goals, in a reasonable timeframe for developmental and clinical status,
3. Therapist's skills are needed to assess functional status, measure progression and create/ modify the plan of care for **ANY** of the following:
    a. Adaptive modifications (eg, speech synthesizer, diet changes)
    b. Aphasia rehabilitation for oral/written comprehension, expression and/or word retrieval.
    c. Cognitive communication disorder rehabilitation
    d. Complication monitoring and care (eg, choking, malnutrition)
    e. Developmental speech/language disorder rehabilitation
    f. Dietary modifications and/or advancement
    g. Dysarthria rehabilitation
    h. Dysphagia rehabilitation
    i. Equipment use and care (eg, adaptive feeding equipment, oral appliances)
    j. Exercise program with progression appropriate to ability and tolerance.
    k. Functional ability loss management (eg, swallowing impairment and use of thickeners)
    l. Fluency disorder rehabilitation
    m. Pain management
    n. Peri-operative procedure rehabilitation (before/after invasive procedure)
    o. Safety techniques (eg, airway protection, aspiration precautions)
    p. Vocal disorder rehabilitation
4. SLP goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:
    a. Adaptive equipment use and care are safely performed independently.
    b. Condition/disease self or supportive care are safely performed independently.
    c. Diet advancement safely to optimal functional level.
    d. Functional ability is improved to maximum independence.
    e. Independent activities of daily living (IADLs) are safely performed independently.
    f. Motor strength (laryngeal, oral, pharyngeal), endurance and range-of-motion (ROM) are improved to maximum independence.

g. Pain is managed optimally.

h. Safety measures are identified, implemented and training demonstrated to maximum independence.

i. Swallowing is improved to maximum functional level.

j. Therapeutic exercises are understood and safely performed independently.

References: [4] [5]

Pediatric Speech Language Pathology (SLP) Continued Outpatient Visits

Pediatric Guideline

Outpatient speech language pathology (SLP) rehabilitation may continue for the same episode of care (EOC) when the documentation demonstrates **ALL** of the following:

1. Care can be performed by individual or support caregiver with adequate cognition (eg, mental ability, memory) **AND** physical capacity (eg, strength, endurance) to participate in therapy program.
2. Child/support caregiver has capability to make measurable improvement toward therapy goals, in a reasonable timeframe for developmental and clinical status,
3. Individual/support caregiver is actively participating in and following-up with treatment.
4. Individual/support caregiver demonstrates measurable progress towards set goals (ie, goals are **NOT** yet met) **OR** maintenance therapy plan evaluation is needed to preserve current function/prevent further deterioration. (*__NOTE__: Functional status should be measured using a validated tool, such as the Functional Improvement Measures (FIM)® tool.
5. SLP goals set appropriate to age/stage of development and including support caregiver assistance, include **ANY** of the following:
    a. Adaptive equipment use and care are safely performed independently.
    b. Condition/disease self or supportive care are safely performed independently.
    c. Diet advancement safely to optimal functional level.
    d. Functional ability is improved to maximum independence.
    e. Independent activities of daily living (IADLs) are safely performed independently.
    f. Motor strength (laryngeal, oral, pharyngeal), endurance and range-of-motion (ROM) are improved to maximum independence.
    g. Pain is managed optimally.

h. Safety measures are identified, implemented and training demonstrated to maximum independence.

i. Swallowing is improved to maximum functional level.

j. Therapeutic exercises are understood and safely performed independently.

References: [4] [5]

Speech Language Pathology (SLP) Outpatient Procedure Codes

Table 1. Outpatient Speech Language Pathology (SLP) Associated Procedure Codes

CODE	DESCRIPTION
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

Outpatient (OP) Speech Language Pathology (SLP) Summary of Changes

Outpatient (OP) Speech Language Pathology (SLP) guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Therapeutic Modalities Procedure Codes

Table 1. Therapeutic Modalities Associated Procedure Codes

CODE	DESCRIPTION
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

CODE	DESCRIPTION
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)

Occupational Therapy (OT) Outpatient Summary of Changes

Occupational Therapy Outpatient guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Outpatient (OP) Physical Therapy (PT) Summary of Changes

Outpatient (OP) Physical Therapy (PT) guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Outpatient (OP) Speech Language Pathology (SLP) Summary of Changes

Outpatient (OP) Speech Language Pathology (SLP) guideline from 2024 to 2025 had the following changes:

- Citations updated per the evidence.
- Evidence reviewed and indications remained the same.

Physical Medicine & Rehabilitation Definitions

Activities of daily living (ADLs) are tasks that people perform to stay healthy and alive. They include eating, dressing, using the toilet, getting in and out of bed, bathing or showering, and walking.

Adaptive equipment refers to devices designed to assist individuals with disabilities in performing activities of daily living and improving mobility, thereby enhancing independence and reducing caregiver burden.

Aphasia rehabilitation, or speech and language therapy, helps people with aphasia improve their communication skills. The goals of aphasia rehabilitation include: restoring lost language abilities, strengthening existing communication skills, teaching compensatory strategies and using aids, and finding alternative ways to communicate.

Dietary modifications can refer to changes made to food preparation, processing, or consumption to increase micronutrient bioavailability or reduce deficiencies. They can also refer

to changes made to your diet to improve your health, such as: eating a variety of nutritious foods, reducing salt intake, cutting back on bad fats, drinking more water, eating more fiber.

Dysarthria rehabilitation can include a variety of treatments and activities, depending on the type and severity of the condition and its cause

Dysphagia rehabilitation is a combination of approaches to improve or compensate for swallowing disorders. Treatments can include: rehabilitative exercises: these exercises are designed to improve swallowing function over time by strengthening muscles or using different muscles to compensate for damaged ones. Some examples include the Shaker exercise, expiratory muscle strength training, and tongue pressure resistance training. Compensatory techniques are techniques that alter swallowing to compensate for deficits that can't be rehabilitated yet. For example, a head rotation can be used to direct food toward the side of the throat during swallowing. Diet modifications can include thickened liquids or modified food textures. Early identification: Screening or assessment can help identify swallowing difficulties early.

Environmental modifications, or E-Mods, are physical changes to a home or vehicle that help people be more independent, safer, and healthier. They can include installing ramps, grab bars, and railings, widening doorways, modifying bathrooms, installing specialized electrical and plumbing systems, adapting lighting or desk height, adding roll-in showers and lifts, installing automatic or manual door openers and doorbells, and adapting cabinets and shelving.

Expressive vocabulary refers to the aspect of language function that involves the production and communication of words and language. Expressive vocabulary encompasses the ability to name objects, describe actions, and formulate sentences, which is essential for effective communication. It is assessed through various neuropsychological and developmental measures, such as the Boston Naming Test and expressive tasks in the WAIS-IV Vocabulary Subtest. Expressive vocabulary development is crucial in early childhood, as it enables children to articulate thoughts, participate in conversations, and influence their environment. Deficits in expressive vocabulary can manifest as difficulties in word retrieval, speech production, and constructing grammatically correct sentences. Expressive vocabulary skills are linked to broader cognitive and academic abilities, influencing a child's learning and social interactions.

Functional ability is a person's capacity to perform activities and tasks that are normal for them, and is a key factor in determining their quality of life. It's a combination of a person's intrinsic capacity and environmental factors, and how they interact.

Functional impairment (FI) is a term used to describe limitations in a person's ability to perform everyday tasks, or to function in social and occupational settings. It can be caused by a number of factors, including congenital or acquired. FI can be present from birth or develop as a result of injury or illness. mental or physical. FI can affect a person's mental functioning or body structure, such as vision, hearing, or movement. Developmental FI can affect language development or growth.

Lymphedema management is the process of reducing swelling and preventing complications in the arms and legs caused by lymphedema.
Mental ability is the capacity to learn, retain, or process information, or the ability to understand the significance of one's behavior.
Pain management is an aspect of medicine and health care involving relief of pain in various dimensions, from acute and simple to chronic and challenging.
Physical Therapy the treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery.
Range of motion (ROM) is the degree of movement a joint can make, from full extension to full flexion, or bending. It's a measurement of flexibility that involves the muscles, tendons, ligaments, bones, and joints.
Receptive vocabulary refers to the ability to understand words and language. It involves the comprehension of spoken or written language without the need to actively produce it. Receptive vocabulary is crucial for effective communication and understanding in both everyday and academic contexts. The development of receptive vocabulary can be influenced by various educational methods, including mobile-assisted learning, which has shown to significantly improve this aspect of vocabulary knowledge. Understanding receptive vocabulary is essential for diagnosing and addressing language-related challenges in clinical settings.
Safety techniques are tools and practices that help prevent accidents and injuries
Therapeutic exercise is a series of physical activities and movements that are prescribed to help improve a patient's health and well-being. It's often used as part of physical therapy to help treat injuries and chronic conditions.

Physical Medicine and Rehabilitation References

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2025 Endoscopic Swallowing Study

Physical Medicine & Rehabilitation

Last Review Date: 03/21/2025
Previous Review Date: 03/20/2024
Guideline Initiated: 03/20/2024

Video Fluoroscopy Contraindications or Exclusions

Video fluoroscopy is contraindicated if the documentation demonstrates **ANY** of the following:

- Aspiration risks to contrast, food or liquid are present.
- Positioning for fluoroscopy is clinically undesirable (eg, bedridden, contractures, ventilator).

Reference: [7]

Endoscopic Swallowing Study Contraindications or Exclusions

An endoscopic swallowing study is contraindicated or excluded if the documentation demonstrates **ANY** of the following:

- Bleeding disorders that are severe.
- Inability mentally/physically to cooperate with the test (eg, severe agitation, movement disorders complicate)
- Nasal passage(s) are obstructed.
- Trauma to the nasal cavity or nearby structures that is recent.

References: [7]

Endoscopic Swallowing Study

Endoscopic Swallowing Study Guideline

An endoscopic swallowing evaluation (or Flexible Endoscopic Evaluation of Swallowing [FEES]) is medically appropriate when the documentation demonstrates **ANY** of the following:

- Dysphagia is severe with absent/weak swallow reflex and/or unable to tolerate aspiration due to clinical status (eg, brainstem stroke, prolonged tube feeding, poor pulmonary/ immunological status).
- Hyper-nasality is suspected (a velum function evaluation).
- Larynx competence evaluation post-intubation or post-surgery where the recurrent laryngeal nerve was vulnerable (eg, coronary artery bypass grafting, carotid endarterectomy).
- Nasal regurgitation is suspected.
- Post-therapeutic swallowing treatment for clinical status evaluation and related care planning update.
- Swallowing evaluation needs to be done over a meal (eg, to assess fatigue-related dysphagia).

- Swallowing maneuver trials to assess swallowing of several foods in a variety of consistencies.
- Video fluoroscopy is contraindicated (*see the Video Fluoroscopy Contraindications section for more information*).
- Video fluoroscopic swallowing study demonstrated pharyngeal dysphagia that needs further evaluation for treatment planning.

References: [1] [2] [3] [4] [5]

Swallowing Study Endoscopy Procedure Codes

Table 1. Swallowing Study Endoscopy Associated Procedure Codes

CODE	DESCRIPTION
92612	Flexible endoscopic evaluation of swallowing by cine or video recording;
92613	Flexible endoscopic evaluation of swallowing by cine or video recording; interpretation and report only
92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording;
92615	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only
92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;
92617	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; interpretation and report only

Swallowing Study Endoscopy Summary of Changes

Swallowing Study Endoscopy guideline from 2024 to 2025 had the following changes:
* Citation updated per the evidence.
* Evidence reviewed and indications remained the same.

Swallowing Study Endoscopy Definitions

Dysphagia is defined as difficulty or inability to swallow. It involves an impairment in the normal process of moving food or liquid from the mouth through the throat (pharynx) and into the esophagus. Dysphagia can affect individuals of all ages and can be caused by a variety of factors, including neurological disorders, structural abnormalities, and muscle weakness. It can range in severity from mild discomfort to an inability to swallow anything at all.
An **Endoscopic Swallowing Evaluation**, also known as a fiberoptic endoscopic evaluation of swallowing (FEES), is a procedure that assesses how well someone swallows. It's used to diagnose swallowing impairments and help determine the best treatments.
Hypernasality is a speech disorder that occurs when too much sound vibrates in the nose while speaking. It can make someone sound like they are talking through their nose

Nasal regurgitation is when food or liquid comes back up into your nose after swallowing. It can happen when the nasopharynx, the part of your throat that connects to your nose, doesn't close properly.

A **swallowing evaluation** is a collection of tests and procedures that assess how well someone swallows. It can help identify swallowing difficulties, also known as dysphagia

A **swallowing maneuver** is a voluntary technique that changes how you swallow to move food or liquid safely to your esophagus. Clinicians use swallowing maneuvers to treat swallowing disorders.

A **videofluoroscopic swallowing study (VFSS)** is an X-ray exam that evaluates swallowing function. It's also known as a modified barium swallow (MBS).

Swallowing Study Endoscopy References

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Disclaimer section

Purpose

The purpose of the HealthHelp's clinical guidelines is to assist healthcare professionals in selecting the medical service that may be appropriate and supported by evidence to safely improve outcomes. Medical information is constantly evolving, and HealthHelp reserves the right to review

and update these clinical guidelines periodically. HealthHelp reserves the right to include in these guidelines the clinical indications as appropriate for the organization's program objectives. Therefore the guidelines are not a list of all the clinical indications for a stated procedure, and associated Procedure Code Tables may not represent all codes available for that state procedure or that are managed by a specific client-organization.

Clinician Review

These clinical guidelines neither preempt clinical judgment of trained professionals nor advise anyone on how to practice medicine. Healthcare professionals using these clinical guidelines are responsible for all clinical decisions based on their assessment. All Clinical Reviewers are instructed to apply clinical indications based on individual patient assessment and documentation, within the scope of their clinical license.

Payment

The use of these clinical guidelines does not provide authorization, certification, explanation of benefits, or guarantee of payment; nor do the guidelines substitute for, or constitute, medical advice. Federal and State law, as well as member benefit contract language (including definitions and specific contract provisions/exclusions) take precedence over clinical guidelines and must be considered first when determining eligibility for coverage. All final determinations on coverage and payment are the responsibility of the health plan. Nothing contained within this document can be interpreted to mean otherwise.

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National and Local Coverage Determination (NCD and LCD)

NOTICE
To ensure appropriate review occurs to the most current NCD and/or LCD, always defer to https://www.cms.gov/medicare-coverage-database/search.aspx.

Background

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) are payment policy documents outlined by the Centers for Medicare and Medicaid Services (CMS) and the government's delegated Medicare Audit Contractors (MACs) that operate regionally in jurisdictions.

CMS introduced variation between different jurisdictions/Medicare Audit Contractors (MACs) and their associated covered code lists with the transition to ICD 10. The variation resulted in jurisdictions independently defining how codes are applied for exclusions, limitations, groupings, ranges, etc. for the medical necessity indications outlined in the NCD and LCD. Due to this variation, there is an inconsistent use/application of codes and coverage determinations across the United States between the different MACs.

In addition, **WITHOUT** notice, CMS can change the codes that indicate medical necessity and the format of the coverage determinations/associated documents (eg, Articles). This is an additional challenge for organizations to keep up with ongoing, unplanned changes in covered codes and medical necessity indications.

Medical Necessity Codes

Due to the variation in code application between jurisdictions/MACs and that updates can happen without notification, HealthHelp is not able to guarantee full accuracy of the codes listed for any Coverage Determination, and advises that prior to use, the associated Coverage Determination Articles are reviewed to ensure applicability to HealthHelp's programs and any associated NCDs and LCDs.

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