OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY PROTOCOL GUIDELINES

General Therapy Guidelines

1. Therapy evaluations must be provided by licensed physical and/or occupational therapists. Therapy evaluations may not be performed by therapy assistants or other medical providers.

2. For workers' compensation patients, physicians may not provide or bill for physical therapy services without employing a licensed therapist to evaluate and supervise treatments.

3. Therapy treatments may be provided by licensed therapy assistants ** as directed by the licensed therapist or by therapy aides under supervision of the licensed therapist.

A facility may not employ more than two licensed assistants per therapist. Physical therapists shall maintain the following documentation regarding the supervision of physical therapy assistants:

1. ON-SITE SUPERVISION OF THE ASSISTANTS PERFORMANCE
2. A REVIEW OF THE ASSISTANTS DOCUMENTATION
3. A REASSESSMENT AND UPDATE OF THE PATIENTS PROGRAM AND GOALS.

** Certified Occupational Therapy Assistants are nationally certified to provide care under the direction of licensed occupational therapists.

4. A course of physical and/or occupational therapy treatment will consist of nine (9) treatments or less. In those few instances where further treatments need to be given, the following format will be followed:

a. The therapist will provide the rationale for continuation of treatment to the employer/insurer.

b. The employer/insurer, usually in correlation with a medical specialist, will make a judgment concerning the medical necessity for further treatment. The employer/insurer will inform the therapist within ten (10) days of receipt of the written or verbal request for continued treatment whether therapy treatment will be reauthorized.

5. Therapy evaluations must identify patient problems and objective measurements of physical or work-skills deficits. These objective measures should be as specific as is possible for the diagnosis or patient problem. Example: Patient diagnosis of rotator cuff strain.

Appropriate

ROM flexion 160, abduction 90, int rotation 45, ext rotation 60.
Unable to reach or lift above shoulder height; able to lift up to 25 lbs from floor to waist.

Inappropriate

ROM limited in all planes.

Unable to lift secondary to pain.

6. Therapy treatment plans must be problem oriented.
7. Therapy evaluations should identify subjective complaints of pain or paresthesias, however, therapy treatments cannot be based solely on pain reduction. Evaluations must identify specific treatment plans and relate treatments to improving objective deficits and patient problems.
8. Frequent reassessment of progress towards improving objective deficits must be done and documented. Timing of reassessment is based on frequency of treatment, but should occur no less than every nine (9) sessions. Revision of problem lists, goals, and treatment plans must be documented at this time.
9. Continuation of treatments cannot be based solely on presence of continued pain symptoms. If objective measures have failed to improve, or have plateaued, the rehabilitation professional will confer with the referring physician to determine if the treatment should be modified or changed.
10. All treatment sessions and tests must be documented in writing. Daily treatment notes must:
    a) identify type of treatment PROVIDED.
    b) note patient response to treatment in subjective and objective terms.
    c) identify any change in treatment plan and reasoning for change; e.g., stopping ultrasound treatment because of diminished tendonitis symptoms and increased ROM.
    d) all assisting personnel notations must be co-signed by the supervising therapist.
11. Most of the treatment protocols anticipate healing and return to work will occur during the first four weeks after injury. There are some patients whose rehabilitation will take longer than the anticipated time frame because of the severity of their injury or the occupational demands of their job. Continuance of the therapy program will be according to the guidelines noted above.

THERAPY PROTOCOLS

LOW BACK MUSCULAR INJURY

... as delineated in the Low Back Musculoligamentous Injury (Sprain/Strain) Medical Advisory Board Protocols.

CERVICAL MUSCULAR NECK INJURY

... as delineated in the Cervical Musculoligamentous Injury (Sprain/Strain) Medical Advisory Board Protocols.

CARPAL TUNNEL SYNDROME

... as delineated in the Carpal Tunnel Syndrome Medical Advisory Board Protocols.

Non-operative Intervention

1. Appropriate Interventions:
   a) ROM and strengthening exercises
   b) splint fabrication
   c) assessment of job skill levels for RTW
   d) instruction in work activities modifications or simulation of work activities
   e) patient education
2. Inappropriate Intervention:
   a) exclusive use of passive modalities
3. Extenuating Services:
   a) prolonged onset of symptoms prior to referral

Post-Operative Intervention

1. Extenuating Circumstances
   a) post-operative complications
   b) delayed referral into therapy

2. Appropriate Interventions:
   a) ROM, simple strengthening exercises
   b) splint fabrication
   c) scar tissue/swelling management
   d) assessment of job skill levels needed for RTW
   e) instruction in work activities modifications or simulation
   f) patient education

CERVICAL HERNIATED DISC

. . . as delineated in the Herniated Cervical Disc Medical Advisory Board Protocols.

Non-operative Intervention

1. Appropriate Interventions:
   a) ROM exercises for neck and upper extremity
   b) strengthening/endurance exercises for upper extremity
   c) trial of cervical traction; if beneficial, a prescription for a home unit is sought
   d) short-term use of modalities for pain relief
   e) patient education
   f) assessment of work skill levels for return-to-work
   g) modification/simulation of work activities

2. Extenuating Circumstances:
   a) profound muscle weakness
   b) delayed referral into therapy

Post-Operative Intervention

1. Extenuating Circumstances:
   a) profound muscle weakness
   b) delayed referral into therapy

2. Appropriate Interventions:
   a) ROM exercises for neck and upper extremity
   b) strengthening/endurance exercises for upper extremity
   c) patient education
   d) modification/simulation of work activities

3) Inappropriate Interventions:
   a) cervical traction
   b) exclusive and/or prolonged use of passive modalities

LUMBAR HERNIATED DISC

. . . as delineated in the Herniated Lumbar Disc Medical Advisory Board Protocols.

Non-operative

1. Appropriate Interventions:
   a) ROM exercises for trunk and extremities
   b) strengthening/endurance exercises for trunk and extremities
   c) short-term use of modalities for pain relief, in conjunction with active exercises
   d) patient education
   e) assessment of work skill levels for return-to-work
   f) work simulation activities (when acute symptoms have subsided) or work-site modifications
   g) short-term trial TENS for chronic pain; if found to relieve symptoms, a referral for a home unit should be sought

2) Inappropriate Interventions:
   a) prolonged and/or exclusive use of modalities

3) Extenuating Circumstances:
   a) delayed referral into therapy
   b) profound muscle weakness (non-operative and post-operative)

Post-operative

1) Appropriate Interventions:
   As above, exceptions noted below.

2) Inappropriate Interventions:
   a) use of passive modalities, including traction

NON-OPERATIVE SOFT TISSUE INJURIES:

SHOULDER SPRAINS, OVERUSE INJURIES, KNEE STRAINS, ANKLE SPRAINS
(Refer to appropriate Medical Advisory Board Protocols.)

1. Appropriate Interventions:
   a) acute management of muscle spasms, pain, and/or swelling
   b) ROM exercises
   c) gait training w/assistive devices, as needed
   d) (as tissue healing progresses) strengthening and endurance exercises
   e) proprioception and balance activities
   f) assessment of job skill levels; job simulation activities if significant deficits noted
   g) isokinetic tests and rehab if deficits noted

2) Inappropriate Interventions:
   a) exclusive and/or prolonged use of passive modalities
   b) multiple computerized tests in any one week

3) Extenuating Circumstances:
   a) further medical evaluation that changes diagnosis
   b) surgery
   c) delayed referral into therapy

MENISCAL INJURIES

Refer to appropriate Medical Advisory Board Protocols.

Non-operative

1. Appropriate Interventions:
   a) ROM and strengthening exercises
   b) acute management of swelling and pain
   c) gait training with assistive devices, as needed
   d) isokinetic testing and rehab.
   e) assessment of work skill levels for return-to-work
   f) work skills simulation

2. Inappropriate Interventions:
   a) prolonged and/or exclusive use of passive modalities

3. Extenuating Circumstances:
   a) delayed referral into therapy
   b) surgery

Post-Operative

As noted above.

SYMPATHETIC DYSTROPHY

. . . as delineated in the Chronic Regional Pain Syndrome (formerly Sympathetic Dystrophy) Medical Advisory Board Protocols.

1. Appropriate Interventions:

   a) ROM exercises (aggressive if done after nerve block)
   b) strengthening and endurance exercises
   c) short-term use of modalities
   d) patient education

e) short-term trial of TENS; if beneficial, a home unit should be sought

f) assessment of work skills levels; simulation of work activities if deficits are found

2. Inappropriate Interventions:
   a) prolonged or exclusive use of modalities

3. Extenuating Circumstances
   a) development of adhesive capsulitis
   b) delayed referral into therapy
   c) repeated nerve blocks with therapy after each procedure

THORACIC OUTLET SYNDROME

1. Appropriate Interventions:
   a) postural exercises and correction
   b) ROM exercises
   c) strengthening and endurance exercises
   d) patient education
   e) assessment of work skills; simulation if deficits are noted

2. Inappropriate Interventions:
   a) prolonged or excessive use of modalities
   b) traction

PROTOCOL HISTORY:
Passed: 3/30/1993
Amended: 5/5/2009