Content Guide to Ambulatory Care

MCG Health
Ambulatory Care
30th Edition

- Ambulatory Care Description
- Ambulatory Care Title and Code
- Ambulatory Care Guidelines
  - Clinical Indications
    - "Current Role Remains Uncertain"
  - Alternatives
  - Evidence Summary
    - Evidence Summary - Background
    - Evidence Summary - Criteria
    - Evidence Summary - Inconclusive or Non-Supportive Evidence
    - Evidence Summary - Rationale
    - Evidence Summary - Related CMS Coverage Guidance
  - Ambulatory Care Annotations
  - References
  - Footnotes
  - Benchmark Statistics Dashboard - Ambulatory Care
  - Rehabilitation Guidelines
    - Ambulatory Care Treatment Plan
    - Visits per Episode
    - Rehabilitation Visit Table and Visits per Episode
  - Referral Management Guidelines
- Statistical Companion to Ambulatory Care
- Abbreviations
- Care Management Tools

Ambulatory Care Description

The purpose of Ambulatory Care guidelines is to provide benchmarks and evidence-based guidance for patient care as one means of enhancing the delivery of optimal healthcare and promoting more efficient resource management across the continuum of care. Ambulatory Care delivers evidence-based guidelines for the assessment, treatment, and management of conditions treated primarily in an ambulatory or outpatient setting. Guidelines cover procedures and diagnostic tests; imaging studies; gene therapy and cellular therapy products; specialty medications; genetic medicine; durable medical equipment, prosthetics, orthotics, and supplies; rehabilitation evaluations, services, and modalities; and referral management. Ambulatory Care can be used by medical directors, physician advisors, case managers, practicing clinicians, and other healthcare professionals. It can serve as a reference document for medical management policies, a resource for

utilization management programs, a vehicle for effective communication about and coordination of ongoing patient care in health plans or medical systems, and evidence of a comprehensive approach to patient care for an accreditation review. The guidelines are designed to be used in conjunction with clinical judgment.

Ambulatory Care Title and Code

Ambulatory Care guidelines are categorized according to resource type, such as Imaging or Procedures and Diagnostic Tests. For identification purposes, each guideline is assigned a Guideline Code (eg, A-0047 for Brain MRI). The prefix "A" designates authorization guidelines, and the prefix "R" designates Referral Management authorization guidelines.

Ambulatory Care Guidelines

Ambulatory Care delivers evidence-based guidelines for the assessment, treatment, and management of conditions treated primarily in an ambulatory or outpatient setting. Ambulatory Care guidelines are categorized as follows:

- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (organized by subspecialty area)
- Genetic Medicine (organized by subspecialty area)
- Imaging (organized by modality, such as CT scan or MRI)
- Procedures and Diagnostic Tests (organized by subspecialty area)
- Referral Management (organized by subspecialty area)
- Rehabilitation (organized by Diagnostic Evaluations, Physical or Occupational Therapy Services, Speech-Language Pathology Services, and Therapeutic Modalities)
- Gene Therapy and Cellular Therapy Products
- Specialty Medications (organized by primary subspecialty area)

Clinical Indications

The Clinical Indications section contains specific criteria that identify when a procedure, treatment, diagnostic test, device, or medication may be indicated. If none of the criteria apply, the appropriateness of using the medical resource may be questioned. It is important to note that every medical situation must be considered individually, and there may be reasons to utilize a resource even when the criteria do not apply. The section uses a format of "ALL of the following" or "1 or more of the following," with nested lists of criteria. On occasion, "2 or more of the following" or "3 or more of the following" is used. Often, there are subsequent subset levels of criteria that may display within expandable and collapsible sections (the user should click the "+" to expand the content). The phrase "ALL of the following" requires that all of the subsequent child bullets be met; the phrase "1 or more of the following" requires that only one of the subsequent child bullets needs to be met. For some guidelines, authorization criteria are not provided, and the following phrase is used instead: "Current Role Remains Uncertain."

"Current Role Remains Uncertain"

Guidelines with the designation "Current Role Remains Uncertain" have no Clinical Indications. "Current Role Remains Uncertain" is a statement used when the available evidence regarding a procedure, treatment, diagnostic test, device, or medication is inadequate to support indications for its use. In some instances, this is because available evidence is insufficient to justify clinical indications. In other instances, existing evidence is conflicting or negative, which precludes listing clinical indications for the medical resource. The use of this statement does not mean that the procedure, treatment, diagnostic test, device, or medication lacks value or that, after careful consideration, it may not be useful for a specific patient in a specific clinical situation.

A complete list of authorization guidelines with the designation "Current Role Remains Uncertain" can be accessed via this link: Guidelines Designated as "Current Role Remains Uncertain" AC. The list can also be accessed via the Ambulatory Care main table of contents page by clicking on the link "Guidelines Designated

as 'Current Role Remains Uncertain,'" located immediately below the Methodology Information section.

Alternatives

The guidelines in Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Genetic Medicine; and Procedures and Diagnostic Tests include an "Alternatives" section. This section identifies procedures, treatments, devices, diagnostic tests, or medications that may be appropriate for some or many patients to use in lieu of the resource that is the subject of the guideline. This section is provided to assist with treatment planning, particularly when it has been determined that the requested medical resource is not appropriate for the patient at a given time.

Evidence Summary

The Evidence Summary may contain a brief description of the procedure, treatment, test, device, or medication that is the subject of the guideline. This description focuses on the resource's uses, benefits, and risks. The Evidence Summary then presents a discussion of evidence that supports indications for use of the medical resource and/or evidence that is inconclusive or does not support indications for use. These designations are determined by critically examining current best evidence from published journal articles, guidelines, and medical textbooks. The reviews, trials, series, reports, and analyses that form the evidence base are cited, summarized, and interpreted throughout the Evidence Summary and serve as the foundation for best practice recommendations for the delivery of healthcare. However, some areas of medical practice are infrequently studied or have less available data for certain aspects of care because a controlled trial may be difficult or impossible to conduct. In fact, many best practices have not been verified by double-blind, placebo-controlled, randomized controlled trials. Therefore, information on best practice may come from a variety of data sources.

The evidence presented in the Evidence Summary is graded according to level of authoritativeness. The evidence hierarchy is as follows:

- **(EG 1) Evidence Grade 1:**
  - Meta-analyses
  - Randomized controlled trials with meta-analysis
  - Randomized controlled trials
  - Systematic reviews
- **(EG 2) Evidence Grade 2:**
  - Observational studies; examples include:
    - Cohort studies with statistical adjustment for potential confounders
    - Cohort studies without adjustment
    - Case series with historical or literature controls
    - Uncontrolled case series
  - Published guidelines
  - Statements in published articles or textbooks
- **(EG 3) Evidence Grade 3:**
  - Unpublished data; examples include:
    - Large database analyses
    - Written protocols or outcomes reports from large practices
    - Expert practitioner reports

Evidence Summary - Background

The Background section briefly describes the nature of a technology (procedure, test, or treatment) that is new, complex, or otherwise not likely to be commonly understood. This section may also discuss relative benefits or hazards of the technology, in comparison to other established procedures, tests, or treatments.

Evidence Summary - Criteria

The Criteria section summarizes evidence of safety and efficacy for a technology that justifies a Clinical Indication and provides additional information, such as comparative benefit, that may assist with decision making regarding use. It also summarizes the types of evidence used in the guideline. Recommendation Grades provide additional insight into the reasoning underlying certain recommendations and the strength of the recommendation. One of three different Recommendation Grades may be assigned to Criteria annotations, as follows:

- **RG A1**: Evidence demonstrates at least moderate certainty of at least moderate net benefit.
- **RG A2**: Evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care.
- **RG A3**: Evidence demonstrates an incomplete assessment of net benefit vs harm; the drug is currently approved by a federal regulatory agency.

Evidence Summary - Inconclusive or Non-Supportive Evidence

The Inconclusive or Non-Supportive Evidence section describes specific diseases or conditions for which a technology has not yet been proven to be of significant benefit (either due to equivocal evidence or a dearth of evidence) or has been shown to be harmful. Each area of uncertainty that is discussed under the heading "Inconclusive or Non-Supportive Evidence" has been assigned a Recommendation Grade summarizing the evidence base for that indication. One of three different Recommendation Grades is used for each area of uncertainty, as follows:

- **RG B**: Evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.
- **RG C1**: Evidence demonstrates a lack of net benefit; additional research is recommended.
- **RG C2**: Evidence demonstrates potential harm that outweighs benefit; additional research is recommended.

Evidence Summary - Rationale

The Rationale section describes the purpose of the clinical indications for Medicare patients.

Evidence Summary - Related CMS Coverage Guidance

Each Ambulatory Care guideline includes additional information that only applies to Medicare patients to identify traditional CMS rules and regulations that overlap with MCG care guidelines.

Ambulatory Care Annotations

With the exception of the Referral Management guidelines, each Ambulatory Care guideline includes evidence annotations. An annotation is a brief summary of the evidence supporting specific Ambulatory Care statements. Types of annotations include the following: Background, Criteria, Inconclusive or Non-Supportive Evidence, and Alternatives. Associated relevant references are also included in each annotation.

Annotations are located immediately after the statement to which the evidence pertains. To view the annotation, click on the "N" icon to produce a pop-up box displaying the evidence; to close the pop-up box, click the "X" in the upper right-hand corner of the pop-up box. This "in-line" location of annotations allows users to quickly access the evidence supporting each statement without navigating to the Evidence Summary.

References

MCG care guidelines include a full reference list that identifies the sources used to develop specific guideline content. Links to references also appear as numbers within parentheses throughout guideline content. Note that a particular reference may pertain to some but not all of the statements made in a guideline section. Furthermore, references are cited for specific pieces of information contained in the article; some of the content within the article may not be pertinent to best

practice. Clicking on the reference number (hyperlink) generates a pop-up box displaying the source. Users also can click on the references link at the top of the guideline or scroll down to the References section. The references list displays sources numerically in the order in which they appear in the text. For each reference, a link is provided to the abstract of the published article when it is available in the public domain, and a digital object identifier (DOI) is also included, when one exists.

Footnotes

Footnotes appear in MCG care guidelines as letters within brackets. Footnotes provide the user with additional clinical and operational information pertinent to the section after which the footnote letter appears. Clicking on the footnote letter generates a pop-up box displaying the full text of the footnote. Users can also click on the Footnotes link at the top of the guideline or scroll down to the Footnotes section to review the text of all footnotes. The footnotes are listed in the order in which they appear in the text.

Benchmark Statistics Dashboard - Ambulatory Care

Ambulatory Care guidelines are linked to a Benchmark Statistics Dashboard, which displays statistical information regarding utilization of services by patients falling under that guideline. The dashboards are accessed by a link marked "Benchmark Statistics" at the top of the guideline page.

The dashboard presents a variety of measures, including unique patients per 1000 population, allowed cost per patient, visits per patient, and allowed cost per member per month.

The data are available for Medicare and Commercial populations, and benchmarks are shown for the total data sample, and for 9 multistate regions of the United States. The dashboard is available for Ambulatory Care guidelines other than the Referral Management guidelines. In some cases, the coding of the underlying data source (health insurance claims) does not permit the differentiation of one guideline from another; in these cases, data for 2 or more guidelines are presented on a combined basis, which is noted on the dashboard. Also, statistics for some guidelines are unavailable due to lack of specific procedure coding to uniquely identify the services covered by the guideline.

Rehabilitation Guidelines

Content in the Rehabilitation section of Ambulatory Care is categorized as follows: Diagnostic Evaluations, Physical or Occupational Therapy Services, Speech-Language Pathology Services, Therapeutic Modalities, and a Rehabilitation Visit Table.

Guidelines in the Diagnostic Evaluations and Therapeutic Modalities sections support authorization for healthcare resources used during the evaluation and treatment of patients undergoing rehabilitation. These guidelines contain the following sections: Clinical Indications, Evidence Summary, References, and Codes. Guidelines in the Physical or Occupational Therapy Services section support authorization and treatment planning for physical and occupational therapy services. Their sections include Clinical Indications, Treatment Plan, Visits per Episode, Evidence Summary, References, and Codes. The same sections are included in Speech-Language Pathology Services guidelines, which support authorization and treatment planning for speech therapy services.

Visits per Episode shows the number of rehabilitation visits per treatment episode for various common diagnoses related to that guideline. For more information, see Rehabilitation Visit Table and Visits per Episode.

Ambulatory Care Treatment Plan

The Treatment Plan section of the Rehabilitation guidelines identifies goals and interventions for the type of rehabilitation being reviewed. This content supports the evaluation of services rendered or the need for ongoing rehabilitation.

Visits per Episode

Visits per Episode identifies the number of rehabilitation visits per treatment episode for various common diagnoses covered by the guideline being reviewed. The content is presented in order of ICD-10 diagnosis codes.

The data source used for this analysis consists of medical claims for outpatient services from a commercially insured nationwide population.

A full Rehabilitation Visit Table is accessible from the Ambulatory Care table of contents page. This table includes a comprehensive listing of rehabilitation data and includes the ICD-10 diagnosis codes. For more information on how the Visits per Episode are derived, and how to use them, see Rehabilitation Visit Table and Visits per Episode.

Rehabilitation Visit Table and Visits per Episode

The Rehabilitation Visit Table shows the distribution of the number of rehabilitation visits per treatment episode for various common diagnoses related to the Rehabilitation Services guidelines. These statistics come from a large national sample of commercially insured individuals. These statistics may be useful for benchmarking against national average performance, or for setting reasonable parameters for initial and subsequent medical review of rehabilitation services. However, the statistics reflect typical rather than optimally managed performance, and do not constitute an evidence-based goal.

The Rehabilitation Visit Table is presented in order of ICD-10 diagnosis codes, with the relevant Rehabilitation guideline identified. If a diagnosis is related to more than one guideline, the statistics will be shown on multiple lines. Visit information is displayed only for those diagnosis codes with at least 60 episodes of 2 or more visits. For many diagnoses/guidelines, 1-visit episodes are common, perhaps representing single evaluation or education visits. To prevent these single visits from distorting the overall statistics, we present the following statistics for each diagnosis/guideline:

- For all episodes (including 1-visit episodes):
  - Number of episodes
  - Percentage of 1-visit episodes
- For episodes with 2 or more visits:
  - Mean (average) visits
  - The 25th, 50th, and 75th percentiles of the number of visits
  - The percentage of episodes continuing longer than 1 year

Users should note that the diagnosis codes associated with a specific guideline in the Rehabilitation Visit Table do not necessarily correspond to the Clinical Indications for that guideline and should not be interpreted as supporting the appropriateness of a specific service for that diagnosis. Similarly, the diagnosis codes associated with a specific guideline in the Rehabilitation Visit Table may not match those listed in the Codes section of the guideline itself; the observational data in the Rehabilitation Visit Table are only intended to portray typical utilization of services by a commercially insured population.

Visit information for the diagnoses associated with each Rehabilitation Service guideline is also included in the body of the guideline in the Visits per Episode section. The data source used for this analysis consists of medical claims for outpatient services from a commercially insured nationwide population (Milliman, Inc. proprietary data sources). Physical and speech rehabilitation episodes were created from claims with service dates between 2022 and 2024. HMO and POS product claims in this sample were excluded because of concerns regarding missing data due to capitated service arrangements.

Claims were selected for inclusion on the basis of CPT®-4 and/or HCPCS codes related to rehabilitation. Because some of these codes are also used by providers who are outside the intended scope of the guidelines (eg, therapeutic modalities that are billed by both physical therapists and chiropractors), claims from inpatient or acute-care hospitals, home health providers, chiropractors, and orthopedic surgeons were excluded.

Episodes of care were created by first finding a service date for a rehabilitation procedure with no prior rehabilitation claim during the previous 90 days. Any subsequent claims, with a gap in service date no longer than 90 days, were grouped into the episode. The most common diagnosis code was then used to describe the episode and assign it to a rehabilitation guideline. The number of visits (as counted by distinct service dates) were summarized for each episode. Enrollment

detail for each patient was reviewed and required for the duration of the episode, including 90 days before the episode start date and 90 days after the end date. Speech rehabilitation episodes were created separately from other rehabilitation services. An episode was flagged to be "Over 1 Year" if associated claims were found more than a year after the episode start date (these claims were not included in the episode description).

Referral Management Guidelines

The Referral Management section in Ambulatory Care contains guidelines for referral of patients from primary care providers to specialists. The section is organized by common diagnoses and conditions. For each diagnosis or condition, the guideline lists clinical indications for referral. These guidelines replace neither the clinical judgment nor the qualifications and experience of an individual provider. They present options for referral care, with actual practice depending on primary care and specialty training, experience, and other factors in the healthcare delivery system.

Statistical Companion to Ambulatory Care

Guidelines in Ambulatory Care provide clinical guidance on the appropriate use of a wide range of procedures. The Statistical Companion to Ambulatory Care provides comparative utilization rates for some of these procedures. It also includes statistics on visits per patient and billed charges. A summary by guideline category is also available.

Abbreviations

The Abbreviations resource lists common medical and MCG care guidelines abbreviations and their corresponding definitions. This resource also provides definitions for units of measurement.

Care Management Tools

Care Management Tools provide additional information on managing particular elements of care. These tools aid case managers and other healthcare professionals in creating and managing the treatment plan, and they help educate the patient and caregiver about treatment. Included in this section are various tools and calculators that address patient monitoring and assessment, and management of specialized types of care. The Care Management Tools section also provides definitions of levels of care across the continuum.

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Last Update: 1/25/2026 1:16:21 AM
Build Number: 30.0.2026012500524.025256