# FLEX CEUs

# Telehealth Rehabilitation: Effective Strategies for Patient Care

# Introduction

Telehealth has become an essential component of rehabilitation practice, expanding rapidly in response to the COVID-19 pandemic and continuing to influence how physical therapists and physical therapist assistants deliver care. This course guides learners through the comparison between virtual and in-person services by examining effectiveness, convenience, accessibility, and the clinical limitations that arise when hands-on assessment or equipment is restricted. It provides a clear explanation of how virtual physical therapy functions, the regulatory requirements that ensure safe and compliant practice, and the technological needs that support successful sessions. Learners also explore the diagnoses that respond well to virtual intervention, strategies for preparing staff and reducing reluctance toward technology use, and methods for addressing challenges such as unstable connections or limited access to therapeutic equipment. The course further reviews documentation, coding, and billing expectations while clarifying how reimbursement for telehealth aligns with or differs from in-person care, and it offers guidance on determining when in-person evaluation or treatment is necessary.

# Section 1: Emergence and Context of Telehealth

The emergence and context of telehealth provide the foundation for understanding how virtual care has become an integral component of modern physical therapy practice. This section introduces the circumstances that propelled telehealth into rapid expansion, beginning with the COVID-19 pandemic and continuing through its integration into routine rehabilitation services. It explains how virtual care compares with traditional in-person visits by examining the strengths and limitations of each approach, and it explores the benefits, concerns, and common pitfalls associated with delivering therapy remotely. The section also

reviews the evidence supporting telehealth's clinical effectiveness and highlights the convenience and accessibility it offers to a wide range of patients. Through this overview, learners gain the essential background needed to understand why telehealth has become a lasting and valuable part of physical therapy.

## Rise of Telehealth Since the COVID-19 Pandemic

**References:** 1

The rise of telehealth in physical therapy can be traced to the unprecedented disruptions caused by the COVID-19 pandemic, during which in-person visits were significantly limited or temporarily halted in order to reduce viral transmission. Clinics faced immediate pressure to maintain continuity of care despite closures, distancing requirements, and reduced patient mobility, prompting a rapid shift toward virtual service delivery. What began as an emergency response quickly evolved into a functional and clinically viable model. State and federal agencies expanded regulatory allowances, granting temporary waivers for remote service delivery, relaxing geographic and originating-site restrictions, and authorizing therapists and assistants to provide care through digital platforms. Many commercial insurers and public payers broadened telehealth coverage, lifting long-standing barriers that had previously restricted reimbursement or limited telehealth to a narrow range of services. These changes created a unique window in which clinicians could adopt telehealth without the usual administrative constraints, allowing the profession to test the model on a large scale.

As therapists adapted, they refined remote communication strategies, developed creative ways to assess movement through video, and established consistent methods for guiding patients through self-directed testing and exercise progression. Clinicians learned how to instruct patients in camera positioning, environmental setup, and safe home-based exercise modifications, thereby

standardizing remote care processes that had not existed before. Meanwhile, patients gained familiarity with video platforms through remote work, school, and social communication, reducing the initial hesitancy or technology-related anxiety that once hindered telehealth participation. This shared learning period, patients and providers adapting simultaneously, resulted in smoother interactions, more efficient virtual sessions, and improved confidence in the feasibility of remote care.

Importantly, outcomes data accumulated throughout the pandemic showed that many musculoskeletal and chronic conditions could be managed effectively through telehealth, with results comparable to those of in-person rehabilitation when sessions were structured, goal oriented, and exercise based. Clinicians recognized that telehealth enhanced certain aspects of practice, particularly the ability to observe patients in their natural environments, provide real-time ergonomic consultation, and address functional limitations within the actual contexts where they occurred. Therapists also noted that telehealth reduced cancellations, expanded access for patients with transportation or mobility challenges, and supported consistent follow-up during vulnerable phases of recovery.

As restrictions lifted, telehealth did not disappear. Instead, it shifted from a crisis-driven alternative to a valuable, sustainable component of modern rehabilitation. Many payers extended telehealth coverage based on positive outcomes and patient demand, and several states enacted parity laws or permanent telehealth policies that solidified its place in clinical practice. Clinics recognized that hybrid models, combining in-person visits for complex assessments with remote sessions for exercise progression, education, and functional retraining, offered flexibility that aligned with patient needs and improved continuity of care.

Today, telehealth remains a mainstay in physical therapy because it expands access, reduces travel-related barriers, supports flexible scheduling, and enhances patient engagement by integrating rehabilitation directly into daily life. Its practicality, effectiveness, and adaptability have reshaped the landscape of rehabilitation, positioning telehealth not as a temporary workaround but as a permanent and essential component of evidence-based practice.

## Comparison Between Telehealth and In-Person Visits

**References:** 1, 2

A clear understanding of the differences between telehealth and in-person physical therapy is essential for making clinically sound decisions about when each mode of care is most appropriate, especially as both formats support rehabilitation in distinct but complementary ways. In-person visits offer the advantage of comprehensive physical examination, allowing therapists to palpate soft tissues to assess tenderness, swelling, turgor, or tissue reactivity; evaluate joint mobility through passive and accessory motion testing; and perform manual muscle testing with the tactile precision needed to differentiate subtle strength deficits or identify neuromuscular inhibition. Therapists can also conduct specialized clinical tests that require controlled force application, such as ligament stress tests, neurodynamic tension tests, or manual provocation maneuvers difficult to reproduce without physical contact. These capabilities are essential for acute injuries, post-operative complications, and complex presentations where tactile input, precise resistance, or direct stabilization is necessary to ensure accurate assessment and safe treatment.

In-person care additionally offers the benefit of immediate access to specialized equipment that enhances both diagnosis and intervention. Clinics provide treatment tables that allow safe positioning for passive motion testing, manual

therapy, or instrument-assisted soft-tissue work. Strengthening equipment such as cable machines, leg presses, and weighted systems allow for progressive overload with measurable resistance. Balance platforms, foam surfaces, perturbation systems, and gait devices support high-level neuromuscular training that cannot be replicated with household items. Modalities including electrical stimulation, therapeutic ultrasound, mechanical traction, and cryotherapy may supplement treatment when appropriate. These resources enable clinicians to create a fully integrated treatment plan that targets impairments across strength, mobility, proprioception, symptom control, and tissue healing.

Telehealth, while lacking the tactile dimension of in-person care, offers a robust and clinically sound alternative that emphasizes movement-based assessment and functional observation. Without manual techniques, therapists rely on detailed subjective interviewing to understand symptom behavior, irritability, onset patterns, aggravating and easing factors, and functional limitations. Guided patient-directed testing allows therapists to approximate special tests by instructing the patient to perform movements, apply self-palpation, or replicate functional tasks while the therapist analyzes visual and verbal feedback. Video observation enables clinicians to assess real-world posture, gait quality, transitional movements, compensatory strategies, lifting mechanics, and workspace ergonomics in the patient's natural environment. These contextual insights often reveal meaningful contributors to symptoms that may not be apparent in a clinic's controlled setting.

Interventions delivered through telehealth place significant emphasis on exercise prescription, technique refinement, symptom management strategies, pain neuroscience education, and environmental or ergonomic modification. Therapists coach patients in real time, helping them adjust alignment, movement sequencing, load distribution, or pacing strategies with the equipment available in the home. Household items such as water jugs, towels, stairs, countertops, and

chairs become practical tools for resistance, balance, and functional conditioning. This approach fosters patient independence and reinforces the continuity between therapy and daily life, promoting long-term adherence and self-efficacy. Research supports that for many musculoskeletal and chronic conditions, including low back pain, knee osteoarthritis, chronic neck pain, and rotator cuff–related shoulder pain, telehealth interventions emphasizing structured exercise and education can achieve outcomes comparable to those of in-person care when implemented with clinical precision.

The choice between virtual and in-person care depends on multiple factors including symptom acuity, the complexity of the presentation, the need for tactile input or advanced testing, the patient's ability to follow instructions, available technology, and environmental safety within the home. Telehealth excels when conditions are stable, predictable, and movement-based, and when real-world functional contexts provide meaningful therapeutic insight. In-person care is essential when safety concerns exist, when hands-on testing and treatment are required, or when specialized equipment is necessary for accurate diagnosis or targeted intervention. When used thoughtfully, both models enhance one another, allowing clinicians to deliver flexible, patient-centered rehabilitation that aligns with clinical needs and optimizes functional outcomes.

## Benefits, Concerns, and Pitfalls

**References:** 3

Telehealth offers clear benefits that have made it a valuable extension of physical therapy practice, particularly for patients who face barriers accessing traditional clinic-based care. Individuals with transportation challenges, chronic medical vulnerabilities, mobility limitations, or complex family and work responsibilities often find virtual visits more feasible and less disruptive to their daily routines.

Patients in rural or underserved communities gain access to specialized services that might otherwise require long travel times or be entirely unavailable. Telehealth also supports consistent attendance by reducing cancellations caused by weather, transportation issues, work conflicts, or minor illnesses that would normally prevent clinic visits. A unique advantage of virtual care is the ability to observe patients in their real-life environments, where factors such as workstation ergonomics, home layout, movement habits, and daily task demands contribute directly to their symptoms and functional performance. This context-rich setting often enhances patient engagement, as individuals can immediately apply therapeutic strategies to the environments and tasks that matter most to them.

Despite these advantages, telehealth introduces concerns and potential pitfalls that require careful clinical judgment and proactive planning. Access to reliable technology varies widely, and patients may struggle with poor internet connections, limited device capabilities, or difficulty navigating video platforms. These challenges can disrupt communication, reduce the therapist's ability to observe movement accurately, or create time constraints that affect session quality. The absence of hands-on assessment limits the therapist's ability to palpate tender areas, assess joint mobility, test tissue integrity, or provide manual interventions when needed. This limitation can complicate the evaluation of acute injuries, post-operative conditions, or complex neuromusculoskeletal presentations that require precise tactile input.

Safety considerations also play a critical role. Patients may perform exercises in confined spaces, on unstable surfaces, or with improvised equipment that lacks appropriate support. Limited visibility from certain camera angles may obscure compensatory movements, increasing the risk of injury if tasks are not adapted properly. Clinicians must verify environmental safety, guide patients in positioning their cameras effectively, and be ready to modify or halt activities that present risk. Ongoing assessment of the patient's ability to follow instructions, maintain

balance, manage equipment, and communicate changes in symptoms is essential for ensuring safe and effective care.

Recognizing these benefits and limitations enables therapists to set realistic expectations, provide clear and precise instructions, and implement strategies that reduce risk while maximizing therapeutic value. By thoughtfully navigating the strengths and constraints of remote care, clinicians can deliver meaningful, patient-centered rehabilitation while safeguarding safety and clinical appropriateness throughout the telehealth encounter.

## Effectiveness, Convenience, and Accessibility

**References:** 4

Evidence has shown that telehealth can produce clinical outcomes comparable to in-person care across a wide range of orthopedic and functional diagnoses when sessions are delivered with structured communication, intentional progression, and adequate technological support. Studies in musculoskeletal rehabilitation indicate that conditions such as nonspecific low back pain, knee osteoarthritis, chronic neck pain, and rotator cuff–related shoulder dysfunction respond particularly well to remote interventions that emphasize therapeutic exercise, movement correction, education, and functional retraining. Research on post-operative rehabilitation following procedures like total knee arthroplasty or ACL reconstruction has demonstrated that, once early healing milestones are met, patients can achieve comparable strength gains, range-of-motion improvements, and functional outcomes through guided telehealth sessions that incorporate progressive loading, gait training, and symptom monitoring. For chronic conditions such as persistent pain syndromes, fibromyalgia, and long-standing mobility impairments, telehealth supports behavior-change models by enabling consistent monitoring of home routines, facilitating regular reinforcement of pacing

strategies, and integrating lifestyle modification directly into the patient's daily environment. These interventions rely heavily on patient participation, guided self-management, and repeated exposure to therapeutic tasks, making them well suited for virtual delivery where active engagement drives progress.

Convenience remains one of the strongest contributors to improved adherence and overall treatment effectiveness in telehealth. By eliminating travel requirements, reducing time spent away from work or caregiving responsibilities, and minimizing logistical barriers such as parking, public transportation, or inclement weather, telehealth enables patients to attend scheduled sessions more reliably. Increased visit consistency is especially beneficial in exercise-based programs where repetition and timely progression determine treatment success. Virtual care allows therapists to provide frequent follow-up, address early symptom changes, and adjust exercise technique or dosage at critical points in recovery. This continuity helps prevent setbacks, reduces treatment gaps, and fosters a sense of ongoing therapeutic support. Patients who might otherwise miss appointments due to scheduling conflicts or transportation challenges are more likely to sustain engagement when sessions can be accessed from home or work.

Accessibility is another central advantage, particularly for individuals living in rural or medically underserved regions where physical therapy clinics may be scarce or specialty services limited. Telehealth allows patients to connect with clinicians who have expertise in specific conditions, such as vestibular rehabilitation, chronic pain management, or post-operative care, even when no local providers offer these services. This expanded reach enhances equity by ensuring that geographic location does not restrict access to high-quality rehabilitation. Telehealth also enables therapists to observe patients performing daily activities in their true environments, such as navigating stairs, lifting household items, performing work tasks, or managing home exercise equipment. This context-rich insight allows

clinicians to tailor interventions more precisely, identify ergonomic or environmental risk factors, and make immediate modifications that directly enhance functional performance.

Taken together, the demonstrated clinical effectiveness, unmatched convenience, and expanded accessibility highlight telehealth as a versatile and patient-centered model that enhances traditional in-person care rather than replacing it. By offering a flexible platform for timely intervention, individualized progression, and meaningful real-world observation, telehealth broadens the rehabilitation toolkit. It allows clinicians to adapt treatment strategies to the diverse needs, environments, and life circumstances of their patients, ultimately supporting high-quality, evidence-informed care across the continuum of physical therapy practice.

## Section 1 Key Words

Telehealth - The delivery of healthcare services through remote communication technologies such as video conferencing, allowing clinicians to evaluate, educate, and guide patients without sharing a physical space

Functional Task Performance - A patient's ability to complete meaningful daily activities such as standing from a chair, reaching overhead, or navigating stairs, and it provides therapists with insight into real-world movement patterns and limitations during virtual sessions

Digital Literacy - A patient's or clinician's ability to use technology effectively, including skills such as navigating video platforms, adjusting device settings, or troubleshooting connectivity problems, and it directly influences the quality and safety of telehealth care

## Section 1 Summary

Telehealth has transformed physical therapy practice since the COVID-19 pandemic by offering a safe and accessible alternative to in-person visits. The model gained rapid acceptance as regulatory changes and expanded payer coverage removed longstanding barriers, allowing clinicians and patients to develop comfort with remote communication technology. Telehealth differs from in-person care by emphasizing movement analysis, patient-guided testing, and education rather than hands-on techniques, yet research shows that many musculoskeletal and chronic conditions respond effectively to this approach. The text highlights telehealth's significant benefits, including improved access, convenience, continuity of care, and the ability to evaluate patients within their home environment, while acknowledging concerns such as limited technology access, reduced tactile examination, and safety considerations during unsupervised activity. Overall, telehealth is presented as a flexible, patient-centered option that complements traditional care, expands rehabilitation access, and supports effective outcomes when implemented with clear communication, appropriate technology, and thoughtful clinical judgment.

# Section 2: Operational Foundations of Virtual Physical Therapy

This section explores the operational foundations of virtual physical therapy by examining the essential components that make remote rehabilitation safe, effective, and clinically rigorous. Virtual care requires intentional planning, structured assessment strategies, and strict adherence to regulatory and ethical standards. Clinicians must adapt their evaluation and treatment methods to rely on visual analysis, precise communication, and patient-guided movement while ensuring that each session meets legal requirements for licensure, privacy, and

documentation. Because telehealth introduces unique environmental and technological variables, therapists must understand how to manage these elements skillfully to protect patient safety and maintain professional accountability. Together, these components form the framework that allows virtual physical therapy to function as a credible and evidence-supported model of care.

## How Virtual Physical Therapy Works

**References:** 3, 5

Virtual physical therapy operates through secure, HIPAA-compliant video platforms that allow clinicians to conduct evaluations and interventions remotely while maintaining the same clinical rigor, safety standards, and evidence-based structure expected in traditional practice. A session typically begins with a comprehensive and highly detailed subjective interview, which takes on even greater importance in the absence of hands-on testing. Therapists explore symptom onset and progression, aggravating and relieving factors, functional impairments, habitual movement patterns, work and home demands, sleep quality, medication use, prior interventions, and the patient's personal goals. Patients may be asked to describe the precise location, quality, and behavior of symptoms during specific tasks, which helps the therapist create a working hypothesis before transitioning to movement-based assessment. This structured questioning provides the foundation for targeted observational testing and compensates for the lack of direct palpation or manual provocation.

Following the subjective component, the therapist guides the patient through a series of movement tasks tailored to the condition being evaluated. Active range-of-motion testing is performed from multiple camera angles to assess symmetry, control, and end-range tolerance. Transitional movements such as sit-to-stand,

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floor transfers, step negotiation, or reaching tasks help reveal functional deficits not always evident in isolated joint testing. Gait analysis is conducted by having the patient walk within their home environment, allowing the therapist to observe stride length, cadence, loading patterns, and compensatory mechanics that may be influenced by flooring surfaces, footwear, or space constraints. Balance challenges such as tandem stance, single-leg stance, weight-shifting, or perturbation simulations (within safe limits) help assess postural stability and neuromuscular coordination. Condition-specific special tests are adapted for telehealth and may include guided self-palpation, positional movements for directional preference assessment, spinal screening through repeated motions, or shoulder and hip tests performed with verbal cueing and modified hand placement. Through careful visual analysis, therapists evaluate alignment, muscle recruitment, breathing patterns, task efficiency, compensatory strategies, and the relationship between movement and symptom behavior—all within the patient's natural surroundings, where functional challenges are most authentic.

Treatment strategies in virtual care rely on precise communication, active patient participation, and thoughtful adaptation of the home environment. Therapists provide individualized exercise prescriptions that include clear, step-by-step instructions on setup, movement sequencing, alignment cues, pacing, and progression. Postural and ergonomic training may involve real-time assessment of desk height, chair support, monitor placement, or household task mechanics. Pain neuroscience education helps patients understand symptom behavior, reduce fear-avoidance, and build confidence in movement. Activity modification strategies address the patient's specific routines, such as lifting children, performing chores, or managing work demands, and are tailored to the unique constraints of the home or workplace.

Real-time feedback during exercise performance enables therapists to refine technique, adjust resistance or intensity, and modify tasks to ensure continued

safety and therapeutic value. When patients lack traditional equipment, clinicians employ creative substitutions using towels for isometric resistance, water jugs for load progression, stairs for functional strengthening, countertops for balance support, pillows for proprioceptive challenges, or backpacks as adjustable weight systems. Throughout the session, the therapist continuously monitors for signs of instability, pain escalation, fatigue, dizziness, or unsafe environmental factors. Camera repositioning is used strategically to enhance visibility during complex tasks, and therapists frequently check that the space remains clear and that the patient understands safety instructions before progressing.

This dynamic, interaction-driven model emphasizes patient empowerment, self-management, and the integration of therapeutic principles into daily routines. Research consistently supports the validity and reliability of remote assessment for many orthopedic conditions and demonstrates that structured, exercise-based telehealth interventions can yield clinical outcomes comparable to in-person care. By combining detailed subjective inquiry, targeted movement analysis, and real-time corrective feedback, virtual physical therapy provides a clinically robust platform for effective rehabilitation while honoring the safety and contextual realities of the patient's everyday environment.

## Federal and State Requirements

**References:** 6, 7

Compliance with federal and state regulations is essential for delivering virtual physical therapy in a manner that is both ethical and legally defensible. Because telehealth laws are determined by the patient's location rather than the clinician's, therapists must be licensed in the state where the patient is physically present during the session or must be eligible to practice through the Physical Therapy Compact if that state participates. Each state defines telehealth

differently, and these definitions influence what services may be provided, whether initial evaluations may occur remotely, and how physical therapist assistants must be supervised. Some states allow PTAs to participate in telehealth under direct or indirect supervision, while others prohibit PTA involvement entirely, reinforcing the need for clinicians to verify state-specific parameters before offering virtual services.

In addition to state regulations, federal guidelines shape the broader framework under which telehealth operates. Federal policies outline expectations for patient safety, privacy protections, professional standards, and the technologies that may be used to exchange health information. Many of these guidelines were modified during the COVID-19 public health emergency to expand access to virtual services, allowing greater flexibility in technology platforms and reimbursement. However, once the public health emergency ended, certain temporary allowances expired or transitioned to permanent form depending on federal and state decisions. As a result, requirements for telehealth delivery continue to evolve, and clinicians must monitor updates from bodies such as the Centers for Medicare and Medicaid Services and state boards of physical therapy to ensure full adherence.

Reimbursement policies also vary widely among payers, with some insurance plans covering telehealth on the same basis as in-person visits and others limiting coverage to specific diagnoses, service types, or visit frequencies. Professional obligations require clinicians to comply not only with legal and regulatory expectations but also with payer-specific rules governing coding, documentation, and eligible service delivery formats. Maintaining current knowledge of licensure rules, interstate practice privileges, supervision requirements, evolving telehealth standards, and payer policies ensures that virtual practice remains compliant, ethically grounded, and aligned with the profession's standards of care.

# HIPAA and Regulatory Compliance

**References:** 8

HIPAA compliance remains a fundamental requirement in telehealth because all virtual sessions involve the transmission, storage, or discussion of protected health information through digital means. To maintain confidentiality and data security, clinicians must use secure, encrypted platforms designed to meet HIPAA technical standards, which include end-to-end encryption, multi-factor authentication options, user access controls, and security features that prevent unauthorized viewing or recording. When third-party video platforms are used, a Business Associate Agreement is required to ensure that the vendor assumes responsibility for safeguarding patient information in accordance with federal law. Clinicians must also verify that both their own software and the patient's application are updated regularly to reduce cybersecurity vulnerabilities.

In addition to technological safeguards, therapists must implement environmental and procedural protections. Conducting sessions in private, sound-controlled spaces reduces the risk of inadvertent disclosure, and clinicians must confirm that no unauthorized individuals are within hearing or visual range during the visit. Therapists should also educate patients on how to secure their own environment by choosing a private location, using headphones if needed, and ensuring that personal data displayed on screens or in the room is not unintentionally shared. Informed consent for telehealth must be obtained and documented, and it should explain the nature of virtual care, potential limitations, risks related to privacy or technology failures, and the patient's right to request in-person services at any time.

Regulatory compliance also extends to accurate documentation of the virtual encounter, including noting the technology used, the patient's location, the clinician's location, verification of identity, and confirmation of consent. Payers

often require specific modifiers or codes that indicate telehealth delivery, and some impose additional criteria such as real-time audio-visual communication rather than audio-only formats. By adhering to HIPAA standards and these broader regulatory expectations, clinicians uphold the ethical and legal standards of digital healthcare and ensure that virtual physical therapy remains a safe, confidential, and trustworthy mode of service delivery.

## Malpractice Liability Considerations

**References:** 7, 9

Malpractice liability in telehealth shares many foundational elements with in-person care, yet the virtual environment introduces unique risks that clinicians must manage proactively. One of the most important steps is verifying that a clinician's malpractice insurance policy explicitly covers telehealth services, as not all standard policies automatically extend to remote practice. Some insurers require policy amendments or addendums to include virtual care, particularly when treating patients across state lines. Failure to obtain appropriate coverage can leave clinicians vulnerable to legal exposure, even when care is delivered appropriately.

The absence of hands-on assessment increases reliance on visual observation and patient-reported information, which may limit the therapist's ability to detect certain red flags or emerging complications. This makes initial screening and ongoing reassessment especially important. Before beginning any physical task, clinicians must confirm that the patient has adequate space, stable flooring, appropriate footwear, and access to any necessary equipment. The therapist should assess the home environment for fall risks, clutter, pets, low lighting, or unstable furniture that may compromise safety. Because the therapist cannot physically intervene if a patient loses balance, selecting appropriate exercises and

verifying the patient's safety capacity becomes essential. Providing clear, step-by-step instructions and confirming patient understanding before movement begins helps further reduce risk.

Communication is another factor that carries malpractice implications. Technical issues such as audio delays, poor video resolution, or disconnections can lead to misunderstandings or incomplete instructions, potentially resulting in injury. Clinicians must be prepared to pause or modify interventions when technical quality declines and should have a protocol for safely discontinuing the session if communication becomes unreliable. Thorough documentation of all technological problems, safety instructions, patient responses, and clinical decisions strengthens the defensibility of care in the event of a malpractice claim.

Recognizing when telehealth is not appropriate is also a critical component of liability mitigation. Patients who present with complex neurological symptoms, acute trauma, progressive weakness, or signs of systemic illness may require in-person evaluation for safety and diagnostic accuracy. Similarly, if a patient fails to progress as expected or continues to experience worsening symptoms despite appropriate virtual interventions, transitioning to a hands-on examination is warranted. By ensuring proper insurance coverage, conducting detailed safety screenings, providing clear communication, documenting care meticulously, and making timely referrals when necessary, clinicians establish a defensible and ethically sound telehealth practice that prioritizes patient safety across all settings.

## Technical and Treatment Requirements Including Internet, Camera, and Platform Needs

**References:** 3, 5, 8

Successful telehealth delivery relies on the seamless combination of technology, environment, and patient preparedness to ensure safe and accurate clinical

interactions. High-speed internet is essential because even brief delays, pixelation, or audio lags can interfere with the therapist's ability to observe movement quality, provide timely cues, or identify potential safety risks. Ideally, both the clinician and patient should connect via wired or strong Wi-Fi networks to maximize stability. Devices such as laptops, tablets, or smartphones must have functioning cameras and microphones, and the camera should be positioned at an angle that allows full-body visibility during key movement assessments. This may require the patient to adjust the device height, distance, or orientation throughout the session to allow the therapist to observe gait, squatting, lifting, or other functional movements from multiple angles. Clear visibility of the spine, hips, knees, and feet is particularly important in musculoskeletal evaluations, and poor camera placement can limit the accuracy of clinical decision-making.

The chosen telehealth platform must not only be HIPAA-compliant but also intuitive for patients of varying technological skill levels. Features such as easy log-in processes, stable video quality, and the ability to adjust audio or camera settings quickly help maintain efficiency. Clinicians should provide pre-session instructions explaining how to access the platform, test audio and video, and troubleshoot basic issues. Supporting the patient beforehand reduces time lost during the session and increases the likelihood of achieving therapeutic goals.

Environmental preparation is another crucial component. Patients should be instructed to set up a well-lit area, preferably with natural light or multiple light sources to minimize shadows that could obscure movement. The therapist should confirm that the environment is free from obstacles such as loose rugs, clutter, unstable furniture, or pets that could increase fall risk. Adequate space is needed for activities such as walking, stepping, or transitioning from floor to standing. Therapists may also coach patients in identifying household items that can serve as exercise tools, such as using a chair for balance support, a towel for stretching, or water bottles and filled bags for resistance training.

While some patients may already own basic exercise equipment such as resistance bands, foam rollers, or dumbbells, telehealth emphasizes adaptability and resourcefulness. Therapists must be skilled in modifying exercises based on the patient's available resources and home layout. Preparing patients in advance by sending a brief list of recommended items or environmental considerations helps optimize the session, reduce interruptions, and maintain safety. By integrating reliable technology, secure platforms, and intentional environmental planning, telehealth sessions can replicate the structure and effectiveness of in-person visits while offering the flexibility and convenience of remote care.

## Section 2 Key Words

Observational Assessment - Structured analysis of patient movement, posture, and functional task performance performed visually through video rather than through tactile examination or hands-on testing

Environmental Adaptation - Modifying the patient's physical surroundings to support safe and effective treatment, including preparing adequate space, optimizing lighting, and using household objects as therapeutic tools

## Section 2 Summary

The operational foundations of virtual physical therapy rely on a combination of strong clinical reasoning, regulatory awareness, and patient-centered environmental planning. Clinicians must be skilled in conducting detailed interviews, performing visually guided assessments, and designing evidence-based interventions that patients can execute safely in their home environment. They must also navigate evolving federal and state regulations, ensure HIPAA compliance, maintain malpractice coverage, and meet the technical requirements necessary for reliable communication and accurate movement analysis. When

these elements are integrated effectively, virtual physical therapy becomes a viable and high-quality approach to rehabilitation that supports accessibility, continuity of care, and strong clinical outcomes across diverse patient populations.

# Section 3: Clinical Suitability and Patient Selection

The clinical suitability of telehealth depends on understanding which patients, diagnoses, and functional presentations respond well to virtual care and which situations require an in-person evaluation to ensure safety and diagnostic accuracy. This section introduces the principles that guide patient selection by examining common conditions that benefit from telehealth, identifying clinical indicators that support remote intervention, and clarifying when direct, hands-on assessment is necessary. By understanding these distinctions, clinicians can make informed decisions that optimize outcomes while maintaining patient safety.

## Common Diagnoses and Conditions That Benefit from Telehealth

**References:** 2, 8, 10

A broad spectrum of musculoskeletal, post-operative, and chronic conditions can be effectively managed through telehealth when treatment emphasizes exercise progression, education, functional retraining, and self-management strategies that can be delivered safely without hands-on intervention. Many common orthopedic conditions rely more on movement observation, load management, and behavior modification than on manual therapy alone, making them well suited for virtual rehabilitation when clinical presentation remains stable and predictable. Nonspecific low back pain, for example, often responds well to telehealth because the therapist can assess symptom behavior through repeated movement testing,

observe functional tasks such as bending and lifting, and guide the patient through corrective strategies in real time. Treatment typically focuses on lumbar mobility, trunk strengthening, postural retraining, and graded exposure to previously aggravating activities, all of which can be progressed effectively through video-based sessions.

Knee osteoarthritis is another condition that adapts well to remote care because evidence consistently supports exercise-based interventions as the primary driver of improvement. Telehealth allows the therapist to monitor quadriceps and hip strengthening techniques, progress functional mobility tasks such as sit-to-stand transitions or step training, and teach joint loading strategies that reduce irritability during daily activities. Patients can practice these tasks in their own living spaces, allowing the therapist to address real-world barriers such as chair height, stair configuration, or uneven flooring. Chronic neck pain and rotator cuff–related shoulder pain also respond successfully to virtual rehabilitation because treatment relies heavily on postural correction, scapular and cervical strengthening, ergonomic modification, and education on movement habits. Through telehealth, the therapist can observe workstation setups, demonstrate corrective strategies, and guide the patient through targeted motor control exercises with precise verbal cueing.

Post-operative rehabilitation can also be delivered through telehealth when patients enter the subacute or later recovery phases and the primary focus shifts to mobility, strengthening, and functional retraining. Individuals recovering from total knee or hip arthroplasty often demonstrate good progress through remote sessions in which the therapist monitors gait mechanics, reviews range-of-motion milestones, and adjusts strengthening programs using resistance bands or household items. Similarly, patients recovering from anterior cruciate ligament reconstruction can participate in later-stage telehealth sessions that target progressive loading, neuromuscular control, and return-to-function tasks,

provided early-phase precautions have been addressed during initial in-person visits. Telehealth reduces the transportation burden during a period when mobility may be limited, while still allowing therapists to deliver meaningful progression and oversight.

Chronic pain syndromes, including fibromyalgia and persistent low back pain, are especially well suited to telehealth because care is rooted in education, pacing strategies, nervous system desensitization, and graded activity exposure rather than hands-on intervention. The virtual setting allows therapists to reinforce self-management, address pain-related beliefs, and integrate cognitive–behavioral approaches within familiar environments where patients encounter their most consistent triggers. Generalized deconditioning and early-stage balance impairments can also be addressed effectively through telehealth when patients can perform movements safely. Remote programs may focus on progressive strengthening, endurance training, dynamic stability tasks, and functional conditioning. The therapist verifies environmental safety at the start of each session and adapts exercises to the space and equipment available.

Telehealth becomes particularly advantageous when functional limitations relate to posture, ergonomics, and task-specific performance. Observing patients in their natural environments provides insight that is often difficult to replicate in a clinic setting. A therapist can analyze workstation ergonomics at a patient's desk, identify poor lifting mechanics in the kitchen or garage, observe stair negotiation in the patient's home, or assess gait deviations in the hallway or backyard. This contextual understanding allows for tailored recommendations that address real-world challenges such as repetitive reaching, prolonged sitting, frequent bending, or awkward household tasks. Treatment in these cases benefits from frequent check-ins, ongoing refinement of home exercise programs, and personalized environmental adjustments that directly influence symptom behavior. Telehealth

therefore enhances the relevance and accuracy of intervention, supporting sustained functional improvement within the patient's daily routines.

## Clinical Indicators for Telehealth versus In-Person Care

**References:** 8

Choosing telehealth or in-person care requires a detailed and systematic evaluation of the patient's physical abilities, safety profile, symptom characteristics, technology capacity, and environmental readiness. Patients appropriate for telehealth must demonstrate the ability to move independently within their home, maintain balance during functional tasks without physical support, and follow verbal and visual instructions reliably. They should be able to adjust camera angles, communicate changes in symptoms clearly, and reproduce movements accurately under real-time cueing. Stable medical status is essential; patients should present with predictable symptom behavior, minimal variability in irritability, and no evidence of red flag indicators such as unexplained weight loss, progressive neurological deficits, saddle anesthesia, bowel or bladder dysfunction, fever of unknown origin, or symptoms suggestive of systemic illness. Telehealth is most effective when treating impairments rooted in modifiable factors such as strength deficits, mobility restrictions, postural dysfunctions, endurance limitations, motor control deficits, and movement coordination challenges. These categories respond well to guided exercise prescription, technique correction, patient education, and self-management strategies that can be delivered safely without hands-on assistance.

In-person care becomes essential when clinical presentations exceed what can be safely or accurately evaluated through a virtual platform. Acute traumatic injuries such as suspected fractures, significant ligament sprains, or direct-impact injuries require in-person assessment for palpation, provocative testing, or radiographic

referral. Post-surgical patients displaying abnormal swelling, incision drainage, increasing redness, warmth, or unexplained pain require direct evaluation to rule out infection or post-operative complications. Rapidly evolving neurological symptoms such as new-onset weakness, sensation loss, altered reflexes, gait ataxia, or progressive radiculopathy demand hands-on neurologic testing to determine urgency and next steps. Severe balance impairments, a history of frequent or unexplained falls, or vertigo that provokes loss of stability cannot be safely monitored through virtual means, particularly when tasks require close physical guarding. Conditions requiring manual therapy—such as high-grade joint mobilizations, soft tissue mobilization for scar restriction, or precise manual muscle testing—necessitate in-person delivery because tactile input and controlled resistance are critical to accurate assessment and effective treatment.

Environmental readiness also plays a pivotal role in determining care mode. Telehealth requires adequate lighting for clear visualization, clutter-free flooring to prevent tripping hazards, and enough open space for the patient to perform movements such as squats, lunges, gait assessment, or transfers without obstruction. Patients must have access to stable surfaces, such as chairs or countertops, for balance support when needed. If the home environment is cramped, dimly lit, uneven, or contains hazards such as loose rugs or narrow pathways, remote sessions may compromise safety. Similarly, if repeated telehealth sessions reveal that the patient struggles with exercise technique, demonstrates poor movement control despite detailed cueing, or fails to progress functionally, an in-person assessment may be necessary to refine the diagnosis, reassess impairment contributors, or introduce tactile facilitation that cannot be replicated virtually.

Selecting the appropriate delivery model involves balancing clinical complexity, patient capability, symptom stability, environmental safety, and therapeutic goals. The decision must reflect evidence-based reasoning, ensuring that the mode of

care, whether telehealth or in-person, allows interventions to be delivered safely, effectively, and with the level of clinical precision required for optimal rehabilitation outcomes.

## Section 3 Key Words

Saddle Anesthesia – A loss or significant reduction of sensation in the areas that would contact a saddle, including the inner thighs, buttocks, and perineal region, requiring immediate medical evaluation due to the risk of permanent neurological damage

Scar Mobilization - A manual therapy technique used to improve the mobility, elasticity, and function of healing or mature scar tissue

## Section 3 Summary

Telehealth is well suited for many musculoskeletal, post-operative, and chronic conditions when treatment relies on exercise, education, and functional retraining. Low back pain, knee osteoarthritis, chronic neck pain, and rotator cuff–related shoulder pain respond particularly well because their core interventions can be performed safely at home. Later-phase post-operative care and chronic pain syndromes also integrate effectively into virtual formats. Telehealth further allows therapists to assess posture, ergonomics, gait, and daily tasks within the patient's own environment. It is most appropriate when patients are medically stable, can move independently, and present with impairments that improve through guided exercise. In-person care is required when red flags, acute injuries, neurological changes, post-surgical complications, environmental safety issues, or limited progress make virtual treatment insufficient.

# Section 4: Workforce Preparation and Session Management

As rehabilitation increasingly incorporates remote options, clinicians must develop confidence with digital platforms, adapt their assessment and communication strategies, and learn how to maintain therapeutic rapport without hands-on interaction. At the same time, therapists must be equipped to navigate technological challenges and modify treatment tasks when equipment is limited, ensuring that telehealth remains safe, effective, and accessible for diverse patients.

## Training Staff and Addressing Reluctance Toward Technology

**References:** 10, 11

Training staff and addressing reluctance toward technology requires a structured approach that not only teaches technical skills but also supports the clinical reasoning and communication adjustments necessary for effective telehealth practice. Successful preparation begins with systematic orientation to the telehealth platform, including account setup, navigation of scheduling and documentation features, and familiarity with security and privacy requirements that ensure compliance with professional and regulatory standards. Clinicians should also receive guided instruction on optimizing camera placement, lighting, and audio quality so that movement patterns, joint angles, and postural alignment can be observed with sufficient clarity for accurate remote assessment. Practical training must include strategies for conducting virtual physical examinations, such as using functional tests, self-palpation techniques, and patient-assisted measurements to gather clinically meaningful information when hands-on assessment is not possible.

Building competence further requires education on verbal cueing methods that compensate for the absence of tactile feedback. Clinicians benefit from learning how to use precise, action-oriented language, graded demonstration, and multi-angle visual instructions to direct patient movement safely and effectively. Structured practice through mock sessions allows staff to rehearse these skills in a low-pressure environment, promoting confidence while revealing areas that need refinement. Supervisors or experienced telehealth providers can offer real-time coaching and debriefing to help clinicians anticipate common patient challenges, refine their pacing and clarity, and strengthen their ability to maintain therapeutic rapport through a screen. This includes training in reading subtle visual cues, managing conversational flow with occasional audio delays, and organizing sessions so they remain efficient and patient-centered.

Reluctance toward technology often emerges from perceived complexity or fear of making mistakes. Targeted training should therefore normalize the learning curve and focus on developing predictable workflows that allow clinicians to move through virtual sessions smoothly. Emphasizing patient safety reinforces clinician confidence, particularly when staff understand how to evaluate environmental risks, confirm patient readiness for exercise, and modify tasks without physical assistance. Highlighting clinical effectiveness through evidence-based examples of positive telehealth outcomes can further reduce skepticism by showing that virtual rehabilitation is not a secondary alternative but a legitimate, research-supported modality. As clinicians experience success through guided practice, structured feedback, and incremental skill-building, reluctance typically diminishes and is replaced by a sense of capability and consistency across the workforce.

# Managing Technical Issues

**References:** 12

Managing technical issues such as unstable connections is an essential component of session planning because technological inconsistency can disrupt clinical flow, compromise safety, and reduce patient confidence in virtual care. Therapists should begin each visit with a systematic technology check that verifies audio clarity, video resolution, lighting adequacy, and camera positioning that allows full visibility of the patient's movement. This brief assessment also provides an opportunity to confirm the stability of the internet connection and to identify environmental factors such as background noise or glare that may interfere with communication or observational accuracy.

When connectivity problems arise during a session, clinicians can preserve therapeutic continuity by transitioning to lower-bandwidth strategies that reduce strain on the connection without sacrificing essential components of care. Temporarily disabling the patient's video feed may improve audio stability, which is critical for delivering instructions and ensuring patient safety. Adjusting camera angles to reduce motion in the frame can decrease data load and prevent video distortion. In more persistent cases, shifting to an audio-only format allows the therapist to continue guiding exercise, education, or symptom review until video can be restored. These adjustments should be presented to patients as routine and manageable, preventing unnecessary alarm or loss of engagement.

Clear contingency planning is essential for maintaining session safety. Prior to beginning treatment, clinicians should confirm that the patient has immediate access to a phone number for backup communication in case the connection drops. This ensures that the therapist can verify the patient's status, provide further instruction, or determine whether it is safe to resume or reschedule the

session. Establishing these expectations upfront helps patients understand the process and reduces anxiety if technical issues occur.

Clinicians must remain attentive to patient frustration throughout technical challenges. Some individuals may feel embarrassed, overwhelmed, or worried that they are causing the problem. Therapists can help maintain rapport by offering reassurance, normalizing connection issues, and guiding patients through straightforward solutions such as moving closer to the router, closing unused applications, or rebooting the platform. Delivering these instructions calmly and in simple, sequential steps supports patient confidence and minimizes downtime. Effective management of technical issues ultimately reinforces a sense of reliability and adaptability, allowing clinical care to proceed smoothly even when technology is imperfect.

## Adapting Treatment When Patients Have Limited Access to Equipment

**References:** 8, 10

Adapting treatment when patients have limited access to equipment requires thoughtful use of household objects and a strong emphasis on functional movement that aligns with the patient's goals and physical capabilities. Clinicians must first determine which elements of a planned intervention can be safely replicated in the home environment and then select household items that provide similar support, resistance, or stability. Chairs can be used for sit-to-stand practice, upper extremity strengthening, or supported balance tasks, while countertops offer a stable surface for closed-chain loading, postural training, or weight-shifting activities. Steps, sturdy boxes, or low platforms enable functional strengthening and step training, and towels or pillowcases can facilitate sliding movements for mobility work. Everyday objects such as books, filled water bottles, or weighted

bags can serve as substitutes for dumbbells or kettlebells when resistance is needed, and these can be progressively loaded to match the patient's tolerance.

Bodyweight exercise remains central in this context because it can be adapted in numerous ways by altering tempo, range of motion, base of support, or leverage to increase or decrease the physical demand. Therapists may progress an exercise by introducing single-limb variations, using longer lever arms, or incorporating holds to enhance muscle activation. Functional environments such as hallways, staircases, and open living spaces support gait training, dynamic balance tasks, and task-specific practice, allowing patients to rehearse movements they perform in daily life. In this way, the home becomes an extension of the clinical setting, enabling rehabilitation activities that are both meaningful and contextually relevant.

Effective adaptation depends on a detailed assessment of the patient's surroundings, including the stability of furniture, the quality of flooring, available space, and lighting. Therapists must identify and remove potential hazards, such as loose rugs or clutter, before initiating dynamic tasks. Clear explanation and demonstration are essential to ensure that patients understand how to position themselves, handle household items safely, and perform exercises with correct movement patterns. When needed, the clinician can adjust camera angles to observe form and provide real-time feedback that supports safe execution.

This approach encourages seamless integration of therapeutic activities into the patient's daily routines, which can enhance adherence and facilitate consistent practice between sessions. By effectively using what patients already have available, clinicians maintain the quality and intent of rehabilitation even when specialized equipment is not accessible, ensuring that treatment remains both practical and clinically effective.

## Section 4 Key Words

Functional Tests - Movement-based assessments that evaluate a patient's ability to perform everyday tasks such as squatting, stepping, or walking based on observation

Closed-Chain Loading – Exercises where the hand or foot remains fixed on a stable surface, creating coordinated movement across multiple joints; enhances stability and functional strength through tasks such as squats, step-ups, or wall push-ups

## Section 4 Summary

Successful telehealth practice depends on a well-prepared workforce, reliable technical management, and the capacity to adapt treatment creatively within the home environment. When clinicians receive structured training, consistent mentorship, and practical experience with virtual assessment and cueing, reluctance toward technology diminishes and confidence grows. Effective handling of connection problems and thoughtful use of household items to replace clinic equipment further supports continuity of care. Together, these skills allow therapists to deliver evidence-based, patient-centered rehabilitation that maintains clinical integrity even when delivered through a digital platform.

# Section 5: Administrative Integration and Referral Decision-Making

As telehealth continues to integrate into mainstream rehabilitation practice, clinicians must understand the documentation standards, billing expectations, and reimbursement structures that govern remote care. Equally important is the ability to recognize when telehealth is appropriate and when a patient's presentation or response to care needs a transition to in-person care. Together,

these elements form the administrative and decision-making framework that ensures high-quality service delivery, protects patient safety, and maintains regulatory compliance.

## Documentation Requirements

**References:** 13, 14

Documentation for telehealth physical therapy should meet all state and federal standards for skilled intervention while addressing the unique features inherent to remote clinical encounters. Clinicians must begin each note by explicitly stating that the session occurred via telehealth, identifying the modality such as synchronous video, and recording the specific platform used. This clarity establishes the encounter type for regulatory, legal, and billing purposes. Consent for telehealth services must be verified and documented at the outset of care, with notes indicating whether the consent was verbal or written, whether the patient was informed of potential risks and limitations, and whether jurisdictional requirements such as identity verification, location confirmation, and disclosure of provider credentials were completed. These elements reinforce patient safety, regulatory compliance, and transparency in the delivery of remote care.

The clinical content of telehealth documentation must capture objective findings that reflect what can be accurately observed or measured through virtual means. This may include movement quality, range of motion estimated through visual approximation, functional task performance, self-palpation results guided by clinician instruction, and patient-generated outcome measures collected electronically. When remote assessment introduces limitations, clinicians should clearly articulate the specific constraints and describe how they informed diagnostic reasoning or treatment decisions. This transparency helps differentiate a skilled clinical evaluation from a casual conversation and underscores the

therapist's ability to adapt evidence-based assessment strategies to a digital format.

Documentation should also include detailed explanations of patient education tailored to the telehealth environment. This may involve guidance on optimizing home camera placement, modifying the immediate environment to ensure safety, and adjusting household items for use as makeshift equipment. Clinicians should describe how they verified the safety of the physical environment, including the patient's ability to perform tasks without excessive fall risk or environmental hazards. Notes should reflect education on pacing strategies, symptom monitoring, and self-directed activities that supplement the physical examination or intervention plan, ensuring that the patient can safely engage in independent components of care.

Thorough documentation must demonstrate that telehealth facilitated medically necessary skilled therapy rather than a mere exchange of advice or general information. This requires clear articulation of clinical reasoning that connects assessment findings to intervention choices, details the therapist's active role in modifying patient performance in real time, and outlines the measurable functional goals targeted through remote care. By presenting telehealth encounters with the same rigor applied to in-person visits, clinicians support defensible practice, appropriate reimbursement, and high-quality patient outcomes in the virtual environment.

## Coding and Billing Expectations

**References:** 14, 15

Coding and billing for telehealth physical therapy services require accurate selection of service codes that align with payer-specific requirements and demonstrate that the encounter met the standards of skilled therapeutic

intervention. Many payers allow therapists to use the same Current Procedural Terminology codes applied during in-person visits because the therapeutic activities, neuromuscular reeducation, therapeutic exercise instruction, and self-management training provided via video can still meet the definition of skilled care when delivered remotely. However, some insurers mandate the use of telehealth-specific modifiers such as the modifiers that identify a service delivered synchronously or modifiers that clarify that the therapist furnished the service through real-time interactive communication. In addition, certain payers require a specific place-of-service code to indicate that the patient participated from a nonclinical location while the provider furnished care from a qualifying clinical site. These indicators must be applied exactly as required, since incorrect coding can trigger denials, recoupment requests, or delays in claims adjudication.

Clinicians must ensure that coding accurately reflects the skilled components of the session and that time-based codes adhere to the same minute-to-minute rules used for in-clinic billing. This includes verifying that the total timed treatment minutes support the units billed and that the interventions documented correspond directly to those units. Telehealth does not alter the definition of "direct treatment time" when the therapist is continuously engaged in cueing, monitoring, correcting movement patterns, or modifying the patient's performance in real time. Therefore, therapists must avoid assumptions that remote encounters are automatically untimed or nonbillable; instead, they must clearly show that skilled, interactive care occurred throughout the session. When therapeutic procedures rely heavily on patient-directed activities, the therapist's ongoing verbal cueing, safety monitoring, and progression decisions should be documented to justify the level of skilled involvement required for each billed code.

Documentation must support the medical necessity of each intervention by linking the skilled components of care to the patient's functional goals,

examination findings, and clinical presentation. Because certain payers scrutinize telehealth claims more closely, therapists should be explicit in describing how they adapted interventions to the remote format, how they ensured safety, and how they provided value equivalent to an in-person encounter. For payers that limit telehealth coverage to specific service categories, therapists need to confirm that the codes billed fall within the allowable set and that they have met any additional requirements such as patient location restrictions, provider type eligibility, or preauthorization rules.

Close familiarity with payer policies is essential because coverage details, allowable codes, modifier requirements, and parity rules differ widely among commercial insurers, Medicare, Medicaid programs, workers' compensation plans, and institutional agreements. Policy updates are frequent and may change with legislative actions, public health declarations, or payer-specific internal reviews. Clinics should maintain updated reference materials and verify coverage during scheduling, as doing so reduces financial risk for both the patient and the provider. Sustained accuracy in coding and billing ultimately supports regulatory compliance, reimbursement integrity, and the long-term viability of telehealth within physical therapy practice.

## Reimbursement for Telehealth and In-Person Services

**References:** 16–18

Reimbursement for telehealth physical therapy often differs from traditional in-clinic services because payers apply varying interpretations of medical necessity, cost structure, and regulatory authority when determining payment levels for remote care. At the state level, two main layers shape reimbursement: state insurance law and state Medicaid policy. For commercial plans, most states now have some form of private payer telehealth law, but not all require equal

payment. Recent national tracking shows that forty-four states plus the District of Columbia, Puerto Rico, and the Virgin Islands have a private payer law addressing telehealth reimbursement, yet only about twenty-four states and Puerto Rico explicitly require payment parity, meaning payers must reimburse telehealth at the same rate as the comparable in-person service. In payment parity states such as Washington and Louisiana, a commercially insured telehealth physical therapy visit must generally be reimbursed at the same rate as an in-person visit for the same covered service, assuming the service meets medical necessity and coding requirements. In contrast, states with coverage parity but not payment parity require insurers to cover telehealth if they cover the service in person, but they allow lower payment levels, narrower code sets, or additional utilization controls for telehealth encounters.

Medicaid reimbursement is governed by state-specific policy rather than parity statutes, and these programs are generally more explicit about which telehealth modalities, provider types, and service categories are covered. All fifty states and the District of Columbia reimburse some form of live video telehealth in Medicaid fee-for-service, and many explicitly include physical and occupational therapy among the services that can be provided remotely when clinically appropriate. However, the details vary considerably by state. Some Medicaid programs reimburse telehealth PT visits using the same codes and rates as in-person care, provided the visit meets the definition of a covered encounter and uses required modifiers. Others restrict telehealth to certain settings, require an initial in-person examination before telehealth follow-ups, or limit which codes (for example, evaluation versus treatment codes) can be billed remotely. A state like Washington, for example, reimburses live video, store-and-forward, remote patient monitoring, and audio-only under Medicaid and also has a private payer law with payment parity, creating a relatively supportive environment for telehealth PT. In other states, Medicaid coverage may be more constrained, with

narrower modality allowances or explicit exclusions for certain hands-on or manual therapy codes when delivered remotely.

Medicare operates under a separate federal framework that overlays state rules. Traditional Medicare maintains a published list of services payable when furnished via telehealth, and physical therapy codes remain on a provisional telehealth list rather than the permanent telehealth list, subject to periodic renewal in the Physician Fee Schedule rulemaking process. During and after the COVID-19 public health emergency, temporary waivers expanded telehealth coverage to include PT and PTA services with the patient's home as an originating site, but those flexibilities are tied to statutory and regulatory timelines. As federal telehealth extensions phase in or out, Medicare coverage for PT telehealth may tighten, particularly around originating site rules, geographic restrictions, and which service codes remain eligible. This means that a PT could be reimbursed for a telehealth visit in one year and then find that the same visit is no longer payable via telehealth in a subsequent year unless Congress or CMS extends the authority.

From a practical standpoint, these layered rules mean that reimbursement for telehealth PT is not purely a clinical question but a jurisdictional one. A therapist licensed in multiple states may find that telehealth PT is fully reimbursable at in-person rates in one state, reimbursable at a reduced rate in another, and only partially covered or restricted to certain codes in a third. Payment parity statutes may protect reimbursement levels for commercial plans, but they do not automatically apply to Medicaid or Medicare, and they usually do not override payer requirements related to telehealth modifiers, place-of-service codes, or documentation standards. For this reason, clinicians and administrators should treat state-specific telehealth policy resources and payer bulletins as working tools rather than background reading. Routinely consulting state telehealth policy finders, Medicaid manuals, and APTA or FSBPT state summaries allows practices to verify, for each state where patients are located, whether telehealth PT is covered,

at what rate relative to in-person care, which codes and modalities are allowed, and whether there are special conditions such as initial in-person examinations, time-limited telehealth authority, or documentation requirements unique to remote care.

A clear understanding of these state-by-state reimbursement rules allows clinics to move beyond generic telehealth planning and instead design telehealth service lines that are financially and operationally tailored to their actual payer mix and geographic footprint. When clinicians and administrators know, at the state level, whether commercial payers are bound by payment parity, how Medicaid reimburses PT via telehealth, and how federal Medicare rules intersect with those state guidelines, they can decide which patients are best served through telehealth, which visit types should remain in person, and how to schedule to protect both access and revenue stability.

## Referral Needs and Criteria for Transitioning to In-Person Visits

**References:** 14, 19

Referral decision-making is critical to the safe use of telehealth because the virtual format changes the clinician's ability to conduct hands-on testing, control the physical environment, and provide direct physical assistance when needed. Clinicians must continually evaluate whether the patient's clinical presentation remains within the scope of what can be safely and effectively managed remotely. This assessment begins during the initial telehealth examination, when therapists determine whether the patient's communication abilities, cognitive status, technological capacity, and physical environment support safe participation. As care progresses, ongoing monitoring of symptoms, functional status, and responsiveness to interventions helps identify when a transition to in-person care becomes necessary.

Several clinical indicators signal that remote management may be insufficient. Persistent or worsening symptoms that cannot be accurately measured or triangulated through observation and patient-directed testing often require hands-on examination. Examples include suspected joint instability, progressive neurologic symptoms such as new-onset weakness or altered sensation, or complex vestibular presentations in which precise positional testing or safety-dependent maneuvers are difficult to perform virtually. Red flag findings such as saddle anesthesia, sudden bowel or bladder changes, severe unrelenting pain, unexplained weight loss, or signs suggestive of systemic involvement require immediate in-person evaluation or referral to an appropriate medical provider. In these cases, telehealth should serve only as a triage point, and the clinician must prioritize rapid transition to in-person or urgent medical assessment.

Safety concerns also play a significant role in referral decisions. When a patient demonstrates balance deficits, mobility limitations, or fatigue levels that make remote supervision insufficient to prevent falls or other injuries, an in-person visit becomes necessary to ensure safe handling, spotting, and environmental control. Similarly, if the home environment presents hazards that cannot be modified adequately through verbal instruction, or if the patient lacks caregiver support that would otherwise facilitate safe participation, the risks of continuing via telehealth outweigh the benefits. By contrast, patients with compensatory strategies or adaptive equipment already in place may still be appropriate for remote care if the therapist can verify environmental safety and monitor performance effectively.

Another important consideration is therapeutic progress. If a patient demonstrates limited or inconsistent improvement despite appropriate and well-documented telehealth intervention, an in-person examination may help uncover biomechanical, neuromuscular, or sensory impairments that are not easily observed through a camera. In-person reassessment allows the clinician to refine

diagnostic hypotheses, modify the plan of care, or incorporate manual therapy or specialized testing that cannot be replicated virtually. For patients requiring interdisciplinary coordination, such as those with suspected medical complications, psychosocial barriers, or comorbidities influencing functional recovery, the therapist may determine that referral to primary care, behavioral health, or specialty providers is indicated in conjunction with or instead of in-person physical therapy.

All referral decisions should be grounded in clear clinical reasoning and communicated transparently to the patient. Therapists should explain why telehealth is no longer the safest or most effective option, outline the expected benefits of in-person evaluation, and help the patient navigate logistics such as scheduling or contacting the appropriate provider. Thorough documentation is essential and should describe the specific clinical findings, safety considerations, or functional limitations that prompted the decision. This record not only supports legal and regulatory requirements but also demonstrates continuity of care and protects the clinician's decision-making process.

Effective referral practices ensure that telehealth functions as an integrated component of the patient's care journey rather than an isolated service. When clinicians recognize the limits of remote care and transition patients appropriately, they maintain patient safety, preserve therapeutic efficiency, and support optimal clinical outcomes across both virtual and in-person settings.

## Section 5 Key Words

Medical Necessity - The clinical justification demonstrating that the services delivered during a telehealth encounter were essential to the patient's functional improvement and could not have been achieved through non-skilled or non-clinical means

<u>Payment Parity</u> - A requirement that telehealth services be reimbursed at the same rate as comparable in-person services when they involve the same provider, same CPT code, and same level of clinical skill

## Section 5 Summary

This section outlines the administrative and clinical frameworks necessary for effective telehealth physical therapy practice. Telehealth encounters must follow rigorous documentation standards that capture consent, platform information, objective findings, and clinical reasoning appropriate to virtual care. Coding and billing require careful adherence to payer-specific policies, including modifiers and place-of-service requirements. Reimbursement structures for telehealth can differ significantly from in-person visits, and clinicians must understand these variations to manage operations efficiently. Finally, referral decision-making is central to patient safety, requiring clinicians to recognize when telehealth is appropriate and when a patient requires in-person evaluation or interdisciplinary coordination.

# Case Study 1

Maria is a forty-eight-year-old office administrator referred to physical therapy for chronic right knee pain related to patellofemoral dysfunction. Her work schedule and caregiving responsibilities make attending in-person therapy challenging, so she opts to begin rehabilitation through telehealth. During the initial virtual evaluation, the therapist confirms that she has a safe home environment, adequate lighting, and stable internet access. Maria demonstrates mild quadriceps weakness, reduced hip abductor control, and pain during functional tasks such as squatting and sit-to-stand transitions. Through real-time video guidance, the therapist observes her movement quality and instructs her in targeted exercises, ensuring proper alignment and load distribution. Over six

weeks, Maria participates in weekly telehealth sessions focused on progressive strengthening, neuromuscular control, workstation modification, and activity pacing. She uses household items for resistance and modifies her desk setup to reduce prolonged knee flexion. Each session includes visual reassessment, symptom monitoring, and incremental progression of her home program. By week six, Maria reports reduced pain during stair negotiation, improved tolerance for prolonged sitting, and greater confidence in managing symptoms independently. Her movement patterns demonstrate improved control, with fewer deviations under therapist supervision. She expresses satisfaction with the telehealth format, noting that the flexibility allowed consistent engagement in therapy without missing sessions due to scheduling barriers.

## Reflection Questions

1. How did the therapist determine that Maria was an appropriate candidate for telehealth rehabilitation, and what specific characteristics supported safe and effective remote participation?

2. What telehealth-specific strategies contributed to the therapist's ability to provide skilled intervention, monitor progress, and ensure ongoing improvement in Maria's function?

3. How would documentation reinforce medical necessity, clinical reasoning, and the appropriateness of continuing care through a fully remote format in this case?

## Responses

1. Maria was an appropriate candidate for telehealth because she demonstrated the cognitive readiness, communication ability, and

technological reliability needed for remote participation. Her home environment was safe and adaptable, allowing the therapist to observe functional tasks clearly. Her impairments were measurable through visual assessment, and she responded effectively to verbal cueing. These factors supported safe and meaningful engagement in telehealth rehabilitation from the outset.

2. Several telehealth-specific strategies contributed to Maria's success. The therapist used repeated real-time visual feedback to refine her movement patterns, customized exercises using common household items, and incorporated environmental modifications to reduce symptom-provoking positions. Regular symptom check-ins, functional reassessment, and progressive loading allowed the therapist to monitor improvements effectively and adjust the plan of care with clinical precision. The consistency afforded by remote sessions also promoted adherence, which played a key role in her functional gains.

3. Documentation would emphasize that telehealth was selected due to patient preference and logistical needs while still meeting all safety and clinical appropriateness criteria. Notes would describe observable objective findings, patient-reported outcomes, and the therapist's skilled involvement in modifying technique, progressing exercises, and addressing symptom responses. Documenting measurable improvements in function, pain levels, and movement quality would support medical necessity and demonstrate that telehealth provided effective, skilled rehabilitation without requiring a transition to in-person care.

# Case Study 2

David is a thirty-six-year-old high school teacher who developed acute mechanical low back pain after lifting classroom supplies. He reports difficulty bending, standing for long periods, and transitioning from sitting to standing. Because his work schedule limits his availability for in-person appointments, he elects to begin physical therapy through telehealth. During the initial virtual evaluation, the therapist confirms a safe home environment, adequate camera positioning, and the absence of red flag symptoms. David demonstrates limited lumbar flexion, stiffness with transitional movements, and partial symptom relief with repeated extension, suggesting a mechanical presentation suitable for remote management.

During the first two weeks, David participates in telehealth sessions focused on repeated movement testing, graded exposure to bending, workstation modification, and progressive strengthening. He initially reports decreased stiffness and improved comfort during standing tasks. However, as therapy progresses, he begins experiencing intermittent radiating pain into the posterior thigh, increased difficulty with weight-bearing tasks, and inconsistent symptom responses that no longer follow predictable mechanical patterns. The therapist observes emerging movement deviations and decreased lumbar control that cannot be fully assessed through video. Repeated movement testing fails to centralize symptoms, and David's single-leg control deteriorates compared with earlier sessions.

These changes suggest an evolving condition that requires hands-on neurologic assessment, precise strength testing, and more controlled loading strategies than can be safely delivered through telehealth. The therapist explains the rationale for transitioning to an in-person evaluation and coordinates follow-up to ensure timely assessment and continuity of care.

## Reflection Questions

1. How did the therapist determine that David was initially appropriate for telehealth-based management?

2. What clinical changes indicated that telehealth was no longer adequate for continued assessment and intervention?

3. How should documentation capture the therapist's reasoning for transitioning from telehealth to in-person evaluation?

## Responses

1. Telehealth was initially appropriate because David's presentation was consistent with a stable mechanical pattern, his environment allowed safe performance of functional tasks, and he had no red flag symptoms requiring immediate in-person care. His ability to follow instructions and his predictable responses to movement-based testing supported the use of a remote format.

2. Telehealth became insufficient when his symptoms shifted to include intermittent radiating pain, decreased control during functional tasks, and loss of predictable mechanical responses. These findings suggested potential neurologic involvement and the need for hands-on examination and more precise diagnostic testing.

3. Documentation should describe the initial justification for telehealth, the patient's early response to care, the specific symptom and functional changes that prompted concern, and the clinical reasoning behind recommending an in-person visit. This ensures regulatory compliance, demonstrates skilled decision-making, and supports continuity across care settings.

# Conclusion

This course strives for participants to achieve a comprehensive understanding of the clinical and administrative factors that shape effective telehealth practice within physical therapy. PTs and PTAs will learn to identify the operational, regulatory, and technological elements required for safe and efficient virtual care, including secure platform use, informed consent processes, HIPAA compliance, and strategies for managing common barriers such as limited home space, camera positioning challenges, or connectivity issues. Participants will develop the ability to select appropriate patients for telehealth by evaluating symptom stability, functional capacity, environmental safety, and the patient's ability to follow instructions, while also recognizing when hybrid or in-person care is necessary due to safety concerns, diagnostic complexity, or the need for hands-on assessment. The course will also strengthen administrative competence by emphasizing accurate documentation tailored to telehealth, appropriate coding and billing practices, and an understanding of payer-specific reimbursement rules that influence service delivery. Equipped with this knowledge, clinicians will be prepared to integrate telehealth confidently into daily workflows, adapt their communication and assessment strategies to the virtual environment, and make evidence-based decisions that ensure patient safety, enhance accessibility, and support optimal clinical outcomes.

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19. TELEHEALTH FOR PROVIDERS: WHAT YOU NEED TO KNOW.

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