

National Coverage Provision

Subject

Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology

NCP Number

PHYSMED-001

Effective Date

*01/01/2008

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Indications and Limitations of Coverage

- I. *Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance (220)*

A comprehensive knowledge of the policies that apply to therapy services cannot be obtained through manuals alone. The most definitive policies are Local Coverage Determinations found at the Medicare Coverage Database <http://www.cms.hhs.gov/center/coverage.asp>. (Also see PHYSMED-009)

A list of Medicare contractors is found at the CMS Web site. Specific questions about all Medicare policies should be addressed to the contractors through the contact information supplied on their Web sites. General Medicare questions may be addressed to the Medicare Regional Offices <http://www.cms.hhs.gov/RegionalOffices/>.

- A. *Definitions*

ACTIVE PARTICIPATION *of the clinician in treatment means that the clinician personally furnishes in its entirety at least one billable service on at least 1 day of treatment.*

ASSESSMENT *is separate from evaluation, and is included in services or procedures, (it is not separately payable). The term assessment as used in Medicare manuals related to therapy services is distinguished from language in Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment, which may be payable). Assessments shall be provided only by clinicians, because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation (see definitions below) is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.*

CERTIFICATION is the physician's/Non-Physician Practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. A certification interval is 30 calendar days or one month, whichever is longer.

CLINICIAN is a term used in this manual and in Pub 100-04, chapter 5, section 10 or section 20, to refer to only a physician, nonphysician practitioner or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law. Clinicians make clinical judgments and are responsible for all services they are permitted to supervise. Services that require the skills of a therapist, may be appropriately furnished by clinicians, that is, by or under the supervision of qualified physicians/NPPs when their scope of practice, state and local laws allow it and their personal professional training is judged by Medicare contractors as sufficient to provide to the beneficiary skills equivalent to a therapist for that service.

COMPLEXITIES are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses (ICD-9 codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

A DATE may be in any form (written, stamped or electronic). The date may be added to the record in any manner and at any time, as long as the dates are accurate. If they are different, refer to both the date a service was performed and the date the entry to the record was made. For example, if a physician certifies a plan and fails to date it, staff may add "Received Date" in writing or with a stamp. The received date is valid for certification/re-certification purposes. Also, if the physician faxes the referral, certification, or re-certification and forgets to date it, the date that prints out on the fax is valid. If services provided on one date are documented on another date, both dates should be documented.

***The EPISODE of Outpatient Therapy** - For the purposes of therapy policy, an outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under the care of a clinician (e.g., for evaluation or treatment) for the current condition(s) being treated by one therapy discipline (PT, or OT, or SLP) until the last date of service for that plan of care for that discipline in that setting.

During the episode, the beneficiary may be treated for more than one condition; including conditions with an onset after the episode has begun. For example, a beneficiary receiving PT for a hip fracture who, after the initial treatment session, develops low back pain would also be treated under a PT plan of care for rehabilitation of low back pain. That plan may be modified from the initial plan, or it may be a separate plan specific to the low back pain, but treatment for both conditions concurrently would be considered the same episode of PT treatment. If that same patient developed a swallowing problem during intubation for the hip surgery, the first day of treatment by the SLP would be a new episode of SLP care.

EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement or decline or change in the patient's condition or functional status that was not anticipated in the plan of care for that interval. Although some regulations and state practice acts require reevaluation at specific intervals, for Medicare payment, re-evaluation must meet Medicare coverage guidelines. The decision to provide a re-evaluation shall be made by a clinician.

***INTERVAL** of certified treatment (certification interval) consists of 90 days or less, based on an individual's needs. A physician/NPP may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report Period.

NONPHYSICIAN PRACTITIONERS (NPP) means physician assistants, clinical nurse specialists, and nurse practitioners who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services.

PHYSICIAN with respect to outpatient rehabilitation therapy services means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine, or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

PATIENT, client, resident, and beneficiary are terms used interchangeably to indicate enrolled recipients of Medicare covered services.

PROVIDERS of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services. To qualify as providers of services, these providers must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made.

Note: that the word PROVIDER in these sections is not used to mean a person who provides a service, but is used as in the statute to mean a facility or agency such as rehabilitation agency or home health agency.

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants are limited in the services they may provide (see §§ VIII 1. and 2.) and may not supervise others.

QUALIFIED PERSONNEL means staff (auxiliary personnel) who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP. See § X of this policy. Qualified personnel may or may not be licensed as therapists but meet all of the requirements for therapists with the exception of licensure.

***SIGNATURE** means a legible identifier of any type acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.4.1.1 (B) concerning signatures.

SUPERVISION LEVELS for outpatient rehabilitation therapy services are the same as those for diagnostic tests defined in 42CFR410.32. Depending on the setting, the levels include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701-729, and 486.150-163. Speech-language pathologists are not suppliers because the Act does not provide coverage of any speech-language pathology services furnished by a speech-language pathologist as an independent practitioner. (See §VIII. 3.)

THERAPIST refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §§VIII. 1. 2. and 3. (Skills of a therapist are defined by the scope of practice for the therapist in the state).

THERAPY (or outpatient rehabilitation services) includes only outpatient physical therapy, occupational therapy and speech-language pathology services paid using the Medicare Physician Fee Schedule or the same services provided in hospitals that are exempt from the hospital Outpatient Prospective Payment System and paid on a reasonable cost basis, including Critical Access Hospitals.

Therapy services referred to in this policy are those skilled rehabilitative services provided according to the standards and conditions in CMS manuals, (e.g., in this chapter and in Pub. 100-04, Medicare Claims Processing Manual, chapter 5), within their scope of practice by qualified professionals or qualified personnel, as defined in this section, represented by procedures found in the American Medical Association's "Current Procedural Terminology (CPT)." A list of CPT (HCPCS) codes is provided in Pub. 100-04, chapter 5, §20, and in Local Coverage Determinations developed by contractors.

Unless modified by the words "maintenance" or "not", the term therapy refers to rehabilitative therapy services as described in §220.2(C). (See PHYSMED-009)

TREATMENT DAY means a single calendar day on which treatment, evaluation or re-evaluation is provided. There could be multiple visits, treatment sessions/encounters on a treatment day.

VISITS OR TREATMENT SESSIONS begin at the time the patient enters the treatment area (of a building, office, or clinic) and continue until all services (e.g., activities, procedures, services) have been completed for that session and the patient leaves that area to participate in a non-therapy activity. It is likely that not all minutes in the visits/treatment sessions are billable

(e.g. rest periods). There may be two treatment sessions in a day, for example, in the morning and afternoon. When there are two visits/treatment sessions, plans of care indicate treatment amount of twice a day.

B. References

Deleted See CMS Pub.100-02 chapter 15 §220 B

C. General

Therapy services are a covered benefit in §§1861(g), 1861(p), and 1861(ll) of the Act. Therapy services may also be provided incident to the services of a physician/NPP under §§1861(s)(2) and 1862(a)(20) of the Act.

Covered therapy services are furnished by providers, by others under arrangements with and under the supervision of providers, or furnished by suppliers (e.g., physicians, NPP, enrolled therapists), who meet the requirements in Medicare manuals for therapy services.

Where a prospective payment system (PPS) applies, therapy services are paid when services conform to the requirements of that PPS. For example, see Pub. 100-04 for a description of applicable Inpatient Hospital Part B and Outpatient PPS rules. Reimbursement for therapy provided to Part A inpatients of hospitals or residents of SNFs in covered stays is included in the respective PPS rates.

Payment for therapy provided by an HHA under a plan of treatment is included in the home health PPS rate. Therapy may be billed by an HHA on bill type 34x if there are no home health services billed under a home health plan of care at the same time (e.g., the patient is not homebound), and there is a valid therapy plan of treatment.

In addition to the requirements described in this chapter, the services must be furnished in accordance with health and safety requirements set forth in regulations at 42CFR484, and 42CFR485.

II. Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services (220.1)

**Reference: 42CFR424.24 and <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> page 155*

Coverage rules for specific services are in Pub. 100-03, the Medicare National Coverage Determinations Manual.

Other payment rules are found in Pub. 100-04, chapter 5.

Since the outpatient therapy benefit under Part B provides coverage only of therapy services, payment can be made only for those services that constitute therapy. In cases where there is doubt about whether a service is therapy, the contractor's local coverage determination (LCD) shall prevail. (See PHYSMED-009)

In order for a service to be covered, it must have a benefit category in the statute, it must not be excluded and it must be reasonable and necessary. Therapy services are a benefit under §1861 of the Act. Consult Pub. 100-08, chapter 13, §13.5.1 for full descriptions of a reasonable and necessary service.

Outpatient therapy services furnished to a beneficiary by a provider or supplier are payable only when furnished in accordance with certain conditions. The following conditions of coverage apply. The requirements noted (+) are also conditions of payment in 42CFR424.24(c) and according to the Act §1835 (a)(2)(D) are the three conditions that must be certified:

- a. + such services are or were required because the individual needed therapy services; and*
- b. + a plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP; and*
- c. + such services are or were furnished while the individual is or was under the care of a physician; and*
- d. Services must be furnished on an outpatient basis.*

All of the conditions are met when a physician/NPP certifies an outpatient plan of care for therapy. Certification is required for coverage and payment of a therapy claim. Each of these conditions is discussed separately in the sections that follow.

III. Outpatient Therapy Must be Under the Care of a Physician/Nonphysician Practitioners (NPP) (Orders/Referrals and Need for Care) (220.1.1)

An order (sometimes called a referral) for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician. However, the certification requirements are met when the physician certifies the plan of care. If the signed order includes a plan of care, no further certification of the plan is required. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.

(The CORF services benefit does not recognize an NPP for orders and certification.)

IV. Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services (220.1.2)

Reference: 42CFR 410.61

A. Establishing The Plan

The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated).

The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the plan, which is described below, is not the same as certifying the plan which, is described in §§III and V.

Outpatient therapy services shall be furnished under a plan established by:

- 1. A physician/NPP (consultation with the treating physical therapist, occupational therapist, or speech-language pathologist is recommended. Only a physician may establish a plan of care in a CORF);*
- 2. The physical therapist who will provide the physical therapy services;*

3. *The occupational therapist who will provide the occupational therapy services;*
or
4. *The speech-language pathologist who will provide the speech-language pathology services.*

The plan may be entered into the patient's therapy record either by the person who established the plan or by the provider's or supplier's staff when they make a written record of that person's oral orders before treatment is begun.

Treatment Under a Plan. *The evaluation and treatment may occur and are both billable either on the same day or at subsequent visits. It is appropriate that treatment begins when a plan is established.*

Therapy may be initiated by qualified professionals or qualified personnel based on a dictated plan after it has been committed to writing and before it is signed. A dictated plan must be signed by close of business on the day following dictation by the person who established it.

Two Plans. *It is acceptable to treat under two separate plans of care when different physician's/NPP's refer a patient for different conditions. It is also acceptable to combine the plans of care into one plan covering both conditions if one or the other referring physician/NPP is willing to certify the plan for both conditions. The Treatment Notes continue to require timed code treatment minutes and total treatment time and need not be separated by plan. Progress Reports should be combined if it is possible to make clear that the goals for each plan are addressed. Separate Progress Reports referencing each plan of care may also be written, at the discretion of the treating clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.*

B. Contents of Plan

The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24 and 410.61)(See Documentation Requirements):

1. *Diagnoses;*
2. *Long term treatment goals; and*
3. *Type, amount, duration and frequency of therapy services.*

**The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.*

**Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. When episodes in the setting are short, measurable goals may not be achievable; documentation should state the clinical reasons progress cannot be shown.*

The type of treatment may be PT, OT, or SLP, or, where appropriate, the type may be a description of a specific treatment or intervention. (For example, where there is a single evaluation service, but the type is not specified, the type is assumed to be consistent with the

therapy discipline (PT, OT, SLP) ordered, or of the therapist who provided the evaluation.). Where a physician/NPP establishes a plan, the plan must be specific to the type (PT, OT, SLP) of therapy planned.

There shall be different plans of care for each type of therapy discipline. Where more than one discipline is treating a patient, each must establish a diagnosis, goals, etc. independently. However, the form of the plan and the number of plans incorporated into one document is not limited as long as the required information is present and related to each discipline separately. For example, a physical therapist may not provide services under an occupational therapist plan of care. However, both may be treating the patient for the same condition at different times in the same day for goals consistent with their own scope of practice

The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed.

The frequency refers to the number of times in a week the type of treatment is provided. Where frequency is not specified, one treatment is assumed. If a scheduled holiday occurs on a treatment day that is part of the plan, it is appropriate to omit that treatment day unless the clinician who is responsible for writing Progress Reports determines that a brief, temporary pause in the delivery of therapy services would adversely affect the patient's condition.

**The duration is the number of weeks, or the number of treatment sessions, for THIS PLAN of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.*

**The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals. For example, it may be clinically appropriate, medically necessary, most efficient and effective to provide short term intensive treatment or longer term and less frequent treatment depending on the individuals' needs.*

**It may be appropriate for therapists to taper the frequency of visits as the patient progresses toward an independent or caregiver assisted self management program with the intent of improving outcomes and limiting treatment time. For example, treatment may be provided 3 times a week for 2 weeks, then 2 times a week for the next 2 weeks, then once a week for the last 2 weeks. Depending on the individual's condition, such treatment may result in better outcomes, or may result in earlier discharge than routine treatment 3 times a week for 4 weeks. When tapered frequency is planned, the exact number of treatments per frequency level is not required to be projected in the plan, because the changes should be made based on assessment of daily progress. Instead, the beginning and end frequencies shall be planned. For example, amount, frequency and duration may be documented as "once daily, 3 times a week tapered to once a week over 6 weeks". Changes to the frequency may be made based on the clinicians clinical judgment and do not require recertification of the plan unless requested by the physician/NPP. The clinician should consider any comorbidities, tissue healing, the ability of the patient and/or caregiver to do more independent self management as treatment progresses, and any other factors related to frequency and duration of treatment.*

**The above policy describes the minimum requirements for payment. It is anticipated that clinicians may choose to make their plans more specific, in accordance with good practice. For example, they may include these optional elements: short term goals, goals and duration for the current episode of care, specific treatment interventions, procedures, modalities or techniques*

and the amount of each. Also, notations in the medical record of beginning date for the plan are recommended but not required to assist Medicare contractors in determining the dates of services for which the plan was effective.

C. Changes to the Therapy Plan

(<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> - page 159)

Changes are made in writing in the patient's record and signed by one of the following professionals responsible for the patient's care:

1. The physician/NPP;
2. The qualified physical therapist (in the case of physical therapy);
3. The qualified speech-language pathologist (in the case of speech-language pathology services);
4. The qualified occupational therapist (in the case of occupational therapy services); or
5. The registered professional nurse or physician/NPP on the staff of the facility pursuant to the oral orders of the physician/NPP or therapist.

**While the physician/NPP may change a plan of treatment established by the therapist providing such services, the therapist may not significantly alter a plan of treatment established or certified by a physician/NPP without their documented written or verbal approval [See §220.1.3(C)]. A change in long-term goals, (for example if a new condition was to be treated) would be a significant change. Physician/NPP certification of the significantly modified plan of care shall be obtained within 30 days of the initial therapy treatment under the revised plan. An insignificant alteration in the plan would be a change in the frequency or duration due to the patient's illness, or a modification of short-term goals to adjust for improvements made toward the same long-term goals. If a patient has achieved a goal and/or has had no response to a treatment that is part of the plan, the therapist may delete a specific intervention from the plan of care prior to physician/ NPP approval. This shall be reported to the physician/NPP responsible for the patient's treatment prior to the next certification.*

**Procedures (e.g., neuromuscular reeducation) and modalities (e.g., ultrasound) are not goals, but are the means by which long and short term goals are obtained. Changes to procedures and modalities do not require physician signature when they represent adjustments to the plan that result from a normal progression in the patient's disease or condition or adjustments to the plan due to lack of expected response to the planned intervention, when the goals remain unchanged. Only when the patient's condition changes significantly, making revision of long term goals necessary, is a physician's/NPP's signature required on the change, (long term goal changes may be accompanied by changes to procedures and modalities).*

V. Certification and Recertification of Need for Treatment and Therapy Plans of Care (220.1.3)

Reference: 42CFR424.24(c)

See specific certification rules for CORF in Pub100-2, Ch, 12, §30(E) and in Pub. 100-01, Ch. 4, §20 for hospital services.

A. Method and Disposition of Certifications

**Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. It is not appropriate for a physician/NPP to certify a plan of care if the patient was not under the care of some physician/NPP at the time of the treatment or if the patient did not need the treatment. Since delayed certification is allowed, the date the certification is signed is important only to determine if it is timely or delayed. The certification must relate to treatment during the interval on the claim. Unless there is reason to believe the plan was not signed appropriately, or it is not timely, no further evidence that the patient was under the care of a physician/NPP and that the patient needed the care is required. For example, if during the course of treatment under a certified plan of care a physician sends an order for continued treatment for 2 more weeks, contractors shall accept the order as certification of continued treatment for 2 weeks under the same plan of care. If the new certification is for less treatment than previously planned and certified, this new certification takes the place of any previous certification. At the end of the 2 weeks of treatment (which might extend more than 2 calendar weeks from the date the order/certification was signed) another certification would be required if further treatment was documented as medically necessary.*

The format of all certifications and re-certifications and the method by which they are obtained is determined by the individual facility and/or practitioner. Acceptable documentation of certification may be, for example, a physician's progress note, a physician/NPP order, or a plan of care that is signed and dated during the interval of treatment by a physician/NPP, and indicates the physician/NPP is aware that therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan when there is evidence the plan was sent (e.g., to the office) or is available in the record (e.g., of the institution that employs the physician/NPP) for the physician/NPP to review.

The certification should be retained in the clinical record and available if requested by the contractor.

B. Initial Certification of Plan

**The physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements noted above in §220.1 for the duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.*

***Timing of Initial Certification.** *The provider or supplier (e.g., facility, physician/NPP, or therapist) should obtain certification as soon as possible after the plan of care is established, unless the requirements of delayed certification are met. "As soon as possible" means that the physician/NPP shall certify the initial plan as soon as it is obtained, or within 30 days of the initial therapy treatment. Since payment may be denied if a physician does not certify the plan, the therapist should forward the plan to the physician as soon as it is established. Evidence of diligence in providing the plan to the physician may be considered by the Medicare contractor during review in the event of a delayed certification.*

**Timely certification of the initial plan is met when physician/NPP certification of the plan is documented, by signature or verbal order, and dated in the 30 days following the first day of treatment (including evaluation). If the order to certify is verbal, it must be followed within 14 days by a signature to be timely. A dated notation of the order to certify the plan should be made in the patient's medical record.*

**Recertification is not required if the duration of the initially certified plan of care is more than the duration (length) of the entire episode of treatment.*

C. Review of Plan and Recertification

Reference: 42CFR424.24(c), 1861(r)

**The timing of recertification changed on January 1, 2008. Certifications signed on or after January 1, 2008, follow the rules in this section. Certifications signed on or prior to December 31, 2007, follow the rule in effect at that time, which required recertification every 30 calendar days.*

**Payment and coverage conditions require that the plan must be reviewed, as often as necessary but at least whenever it is certified or recertified to complete the certification requirements. It is not required that the same physician/NPP who participated initially in recommending or planning the patient's care certify and/or recertify the plans.*

**Recertifications that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initiation of treatment under that plan, unless they are delayed.*

***Physician/NPP Options for Certification.** *A physician/NPP may certify or recertify a plan for whatever duration of treatment the physician/NPP determines is appropriate, up to a maximum of 90 calendar days. Many episodes of therapy treatment last less than 30 calendar days. Therefore, it is expected that the physician/NPP should certify a plan that appropriately estimates the duration of care for the individual, even if it is less than 90 days. If the therapist writes a plan of care for a duration that is more or less than the duration approved by the physician/NPP, then the physician/NPP would document a change to the duration of the plan and certify it for the duration the physician/NPP finds appropriate (up to 90 days). Treatment beyond the duration certified by the physician/NPP requires that a plan be recertified for the extended duration of treatment. It is possible that patients will be discharged by the therapist before the end of the estimated treatment duration because some will improve faster than estimated and/or some were successfully progressed to an independent home program.*

**Physicians/NPPs may require that the patient make a physician/NPP visit for an examination if, in the professional's judgment, the visit is needed prior to certifying the plan, or during the planned treatment. Physicians/NPPs should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care that is certified. If the physician wishes to restrict the patient's treatment beyond a certain date when a visit is required, the physician should certify a plan only until the date of the visit. After that date, services will not be considered reasonable and necessary due to lack of a certified plan. Physicians/NPPs should not sign a certification if they require a visit and a visit was not made. However, Medicare does not require a visit unless the National Coverage Determination (NCD) for a particular treatment requires it (e.g., see Pub. 100-03, §270.1 - Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds).*

Restrictions on Certification. *Certifications and re-certifications by doctors of podiatric medicine must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable state law. Optometrists may order and certify only low vision services. Chiropractors may not certify or recertify plans of care for therapy services.*

D. Delayed Certification

References: §1835(a) of the Act; 42CFR424.11(d)(3)

**Certifications are required for each interval of treatment based on the patient's needs, not to exceed 90 calendar days from the initial therapy treatment. Certifications are timely when the initial certification (or certification of a significantly modified plan of care) is dated within 30 calendar days of the initial treatment under that plan. Recertification is timely when dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less. Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable without justification for 30 days after they are due. Delayed certification should include one or more certifications or recertifications on a single signed and dated document.*

Delayed certifications should include any evidence the provider or supplier considers necessary to justify the delay. For example, a certification may be delayed because the physician did not sign it, or the original was lost. In the case of a long delayed certification (over 6 months), the provider or supplier may choose to submit with the delayed certification some other documentation (e.g., an order, progress notes, telephone contact, requests for certification or signed statement of a physician/NPP) indicating need for care and that the patient was under the care of a physician at the time of the treatment. Such documentation may be requested by the contractor for delayed certifications if it is required for review.

It is not intended that needed therapy be stopped or denied when certification is delayed. The delayed certification of otherwise covered services should be accepted unless the contractor has reason to believe that there was no physician involved in the patient's care, or treatment did not meet the patient's need (and therefore, the certification was signed inappropriately).

**EXAMPLE: Payment should be denied if there is a certification signed 2 years after treatment by a physician/NPP who has/had no knowledge of the patient when the medical record also shows e.g., no order, note, physician/NPP attended meeting, correspondence with a physician/NPP, documentation of discussion of the plan with a physician/NPP, documentation of sending the plan to any physician/NPP, or other indication that there was a physician/NPP involved in the case.*

**EXAMPLE: Payment should not be denied, even when certified 2 years after treatment, when there is evidence that a physician approved needed treatment, such as an order, documentation of therapist/physician/NPP discussion of the plan, chart notes, meeting notes, requests for certification, certifications for intervals before or after the service in question, or physician/NPP services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.*

**EXAMPLE: Subsequent certifications of plans for continued treatment for the same condition in the same patient may indicate physician certification of treatment that occurred between certification dates, even if the signature for one of the plans in the episode is delayed. If a certified plan of care ends March 30th and a new plan of care for continued treatment after March 30th is developed or signed by a therapist on April 15th and that plan is subsequently certified, that certification may be considered delayed and acceptable effective from the first treatment date after March 30th for the frequency and duration as described in the plan. Of course, documentation should continue to indicate that therapy during the delay is medically necessary, as it would for any treatment. The certification of the physician/NPP is interpreted as*

involvement and approval of the ongoing episode of treatment, including the treatment that preceded the date of the certification unless the physician/NPP indicates otherwise.

E. Denials Due to Certification

Denial for payment that is based on absence of certification is a technical denial, which means a statutory requirement has not been met. Certification is a statutory requirement in SSA 1835(a)(2) - ('periodic review' of the plan).

For example, if a patient is treated and the provider/supplier cannot produce (on contractor request) a plan of care (timely or delayed) for the billed treatment dates certified by a physician/NPP, then that service might be denied for lack of the required certification. If an appropriate certification is later produced, the denial shall be overturned.

In the case of a service furnished under a provider agreement as described in 42CFR489.21, the provider is precluded from charging the beneficiary for services denied as a result of missing certification.

However, if the service is provided by a supplier (in the office of the physician/NPP, or therapist) a technical denial due to absence of a certification results in beneficiary liability. For that reason, it is recommended that the patient be made aware of the need for certification and the consequences of its absence.

A technical denial decision may be reopened by the contractor or reversed on appeal as appropriate, if delayed certification is later produced.

VI. Requirement That Services Be Furnished on an Outpatient Basis (220.1.4)

Reference: 42CFR410.60 <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> page 163

Therapy services are payable under the Physician Fee Schedule when furnished by

- 1. a provider to its outpatients in the patient's home;*
- 2. a provider to patients who come to the facility's outpatient department;*
- 3. a provider to inpatients of other institutions, or*
- 4. a supplier to patients in the office or in the patient's home. (CORF rules differ on providing therapy at home.)*

Coverage includes therapy services furnished by participating hospitals and SNFs to their inpatients who have exhausted Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of therapy services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered therapy services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of therapy services may furnish such services to inpatients of another health facility.

A certified distinct part of an institution is considered to be a separate institution from a nonparticipating part of the institution. Consequently, the certified distinct part may render covered therapy services to the inpatients of the non-certified part of the institution or to outpatients. The certified part must bill the intermediary under Part B.

Therapy services are payable when furnished in the home at the same physician fee schedule payments as in other outpatient settings. Additional expenses incurred by providers due to travel to a person who is not homebound will not be covered.

Under the Medicare law, there is no authority to require a provider to furnish a type of service. Therefore, a hospital or SNF may furnish therapy to its inpatients without having to set up facilities and procedures for furnishing those services to its outpatients. However, if the provider chooses to furnish a particular service, it may not charge any individual or other person for items or services for which the individual is entitled to have payment made under the program because it is bound by its agreement with Medicare. Thus, whenever a hospital or SNF furnishes outpatient therapy to a Medicare beneficiary (either directly or under arrangements with others) it must bill the program under Part B and may charge the patient only for the applicable deductible and coinsurance.

VII. Reasonable and Necessary Outpatient Rehabilitation Therapy Services (220.2)
References: Pub. 100-08, Ch. 13, §13.5.1; 42CFR410.59; 42CFR410.60

A. General

To be covered, services must be skilled therapy services as described in this chapter and be rendered under the conditions specified. Services provided by professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services. Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed.

Services which do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions for therapy services. For example, services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes. Also, services not provided under a therapy plan of care, or are provided by staff who are not qualified or appropriately supervised, are not covered or payable therapy services.

Examples of coverage policies that apply to all outpatient therapy claims are in this chapter, in Pub. 100-04, chapter 5, and Pub. 100-08, chapter 13. Some policies in other manuals are repeated here for emphasis and clarification. Further details on documenting reasonable and necessary services are found in the Documentation Requirements section of this policy.

B. Reasonable and Necessary

To be considered reasonable and necessary the following conditions must each be met: (This is a representative list of required conditions and does not fully describe reasonable and necessary services. See the remainder of this section and associated information in the Documentation Requirement section of this policy.)

The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:

Medicare manuals (such as this manual and Publications 100-03 and 100-04),

**Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd>, and*

Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.

The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a qualified therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.

While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel. See item C for descriptions of skilled (rehabilitative) services.

There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and

The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

NOTE: Claims for therapy services denied because they are not considered reasonable and necessary are excluded by §1862(a)(1) of the Act and are thus subject to consideration under the waiver of liability provision in §1879 of the Act.

C. *Rehabilitative Therapy*

Description of Rehabilitative Therapy. The concept of rehabilitative therapy includes recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, or decrease in severity, or rationalization for an optimistic outlook to justify continued treatment.

Covered therapy services shall be rehabilitative therapy services unless they meet the criteria for maintenance therapy requiring the skills of a therapist described below. Rehabilitative therapy services are skilled procedures that may include but are not limited to:

Evaluations; reevaluations

Establishment of treatment goals specific to the patient's disability or dysfunction and designed to specifically address each problem identified in the evaluation;

Design of a plan of care addressing the patient's disorder, including establishment of procedures to obtain goals, determining the frequency and intensity of treatment;

Continued assessment and analysis during implementation of the services at regular intervals;

Instruction leading to establishment of compensatory skills;

Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system); and

Patient and family training to augment rehabilitative treatment or establish a maintenance program. Education of staff and family should be ongoing through treatment and instructions may have to be modified intermittently if the patient's status changes.

Skilled Therapy. *Rehabilitative therapy occurs when the skills of a therapist, are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation.*

(See also Documentation Requirement for documentation of skilled therapy.)

Skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition. In the case of a progressive degenerative disease, for example, service may be intermittently necessary to determine the need for assistive equipment and establish a program to maximize function. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.

Services that can be safely and effectively furnished by non-skilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services. If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, or does not legitimately require the services of a qualified professional for management of a maintenance program as described below, the services will no longer be considered reasonable and necessary. Services that are not reasonable or necessary should be excluded from coverage under §1862(a)(1) of the Act.

Potential for Improvement Due to Treatment. *If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, therapy would not be covered because it is not considered rehabilitative or reasonable and necessary.*

Improvement is evidenced by successive objective measurements whenever possible (see objective measurement instruments for evaluation in the §220.3.C of this chapter).

Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered. (See exceptions for maintenance below.)

D. Maintenance Programs

During the last visits for rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized skill, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.

Where a maintenance program is not established until after the rehabilitative physical therapy program has been completed (and the skills of a therapist are not necessary) development of a maintenance program would not be considered reasonable and necessary for the treatment of the patient's condition. It would be excluded from coverage under §1862(a)(1) of the Act unless the patient's safety was at risk (see below).

Example: A Parkinson patient who has been under a rehabilitative physical therapy program may require the services of a therapist during the last week or two of treatment to determine what type of exercises will contribute the most to maintain the patient's present functional level following cessation of treatment. In such situations, the design of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist, the instruction of the patient or family members in carrying out the program, and such infrequent reevaluations as may be required would constitute covered therapy because of the need for the skills of a qualified professional.

Evaluation and Maintenance Plan Without Rehabilitative Treatment. After the initial evaluation of the extent of the disorder, illness, or injury, if the treating qualified professional determines the potential for rehabilitation is insignificant, an appropriate maintenance program may be established prior to discharge. Since the skills of a therapist are required for the development of the maintenance program and training the patient or caregivers, this service is covered.

Example: The skills of a qualified speech-language pathologist may be covered to develop a maintenance program for a patient with multiple sclerosis, for services intended to prevent or minimize deterioration in communication ability caused by the medical condition, when the patient's current medical condition does not yet justify the need for the skilled services of a speech-language pathologist. Evaluation, development of the program and training the family or

support personnel would require the skills of a therapist and would be covered. The skills of a therapist are not required and services are not covered to carry out the program.

Skilled Maintenance Therapy for Safety. *If the services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may be necessary for the safe and effective delivery of such services. When the patient's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.*

Example. *Where there is an unhealed, unstable fracture, which requires regular exercise to maintain function until the fracture heals; the skills of a therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.*

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VIII Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology (230)

1. Group Therapy Services.

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Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

2. Therapy Students

A. General

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present "in the room".

EXAMPLES:

Therapists may bill and be paid for the provision of services in the following scenarios:

The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.

The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.

The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services).

B. Therapy Assistants as Clinical Instructors

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

C. Services Provided Under Part A and Part B

The payment methodologies for Part A and B therapy services rendered by a student are different. Under the MPFS (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or Resource Utilization Group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determines the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

I. Practice of Physical Therapy (230.1)

***A. General**

Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. (See Pub. 100-03, the Medicare National Coverage Determinations Manual, for specific conditions or services.)

***B. Qualified Physical Therapist Defined**

Reference: 42CFR484.4

The new personnel qualifications for physical therapists were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that a qualified physical therapist (PT) is a person who is licensed, if applicable, as a PT by the state in which he or she is practicing unless licensure does not apply, has graduated from an accredited PT education program and passed a national examination approved by the state in which PT services are provided. The phrase, "by the state in which practicing" includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services. The curriculum accreditation is provided by the Commission on Accreditation in Physical Therapy Education (CAPTE) or, for those who graduated before CAPTE, curriculum approval was provided by the American Physical Therapy Association (APTA). For internationally educated PTs, curricula are approved by a credentials evaluation organization either approved by the APTA or identified in 8 CFR 212.15(e) as it relates to PTs. For example, in 2007, 8 CFR 212.15(e) approved the credentials evaluation provided by the Federation of State Boards of Physical Therapy (FSBPT) and the Foreign Credentialing Commission on

Physical Therapy (FCCPT). The requirements above apply to all PTs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

Physical therapists whose current license was obtained on or prior to December 31, 2009, qualify to provide PT services to Medicare beneficiaries if they: graduated from a CAPTE approved program in PT on or before December 31, 2009 (examination is not required); or,

graduated on or before December 31, 2009, from a PT program outside the U.S. that is determined to be substantially equivalent to a U.S. program by a credentials evaluating organization approved by either the APTA or identified in 8 CFR 212.15(e) and also passed an examination for PTs approved by the state in which practicing.

Or, PTs whose current license was obtained before January 1, 2008, may meet the requirements in place on that date (i.e., graduation from a curriculum approved by either the APTA, the Committee on Allied Health Education and Accreditation of the American Medical Association, or both).

Or, PTs meet the requirements who are currently licensed and were licensed or qualified as a PT on or before December 31, 1977, and had 2 years appropriate experience as a PT, and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Or, PTs meet the requirements if they are currently licensed and before January 1, 1966, they were:

admitted to membership by the APTA; or

admitted to registration by the American Registry of Physical Therapists; or

graduated from a 4-year PT curriculum approved by a State Department of Education;

or

licensed or registered and prior to January 1, 1970, they had 15 years of full-time experience in PT under the order and direction of attending and referring doctors of medicine or osteopathy.

Or, PTs meet requirements if they are currently licensed and they were trained outside the U.S. before January 1, 2008, and after 1928 graduated from a PT curriculum approved in the country in which the curriculum was located, if that country had an organization that was a member of the World Confederation for Physical Therapy, and that PT qualified as a member of the organization.

For outpatient PT services that are provided incident to the services of physicians/NPPs, the requirement for PT licensure does not apply; all other personnel qualifications do apply. The qualified personnel providing PT services incident to the services of a physician/NPP must be trained in an accredited PT curriculum. For example, a person who, on or before December 31, 2009, graduated from a PT curriculum accredited by CAPTE, but who has not passed the national examination or obtained a license, could provide Medicare outpatient PT therapy services incident to the services of a physician/NPP if the physician assumes responsibility for the services according to the incident to policies. On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide PT services incident to the services of a physician/NPP.

***C. Services of Physical Therapy Support Personnel**

Reference: 42CFR 484.4

Personnel Qualifications. *The new personnel qualifications for physical therapist assistants (PTA) were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.*

The regulation provides that a qualified PTA is a person who is licensed as a PTA unless licensure does not apply, is registered or certified, if applicable, as a PTA by the state in which practicing, and graduated from an approved curriculum for PTAs, and passed a national examination for PTAs. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location or the entity billing for the services. Approval for the curriculum is provided by CAPTE or, if internationally or military trained PTAs apply, approval will be through a credentialing body for the curriculum for PTAs identified by either the American Physical Therapy Association or identified in 8 CFR 212.15(e).

A national examination for PTAs is, for example the one furnished by the Federation of State Boards of Physical Therapy. These requirements above apply to all PTAs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

Those PTAs also qualify who, on or before December 31, 2009, are licensed, registered or certified as a PTA and met one of the two following requirements:

- 1. Is licensed or otherwise regulated in the state in which practicing; or*
- 2. In states that have no licensure or other regulations, or where licensure does not apply, PTAs have:*

graduated on or before December 31, 2009, from a 2-year college-level program approved by the APTA or CAPTE; and
o effective January 1, 2010, those PTAs must have both graduated from a CAPTE approved curriculum and passed a national examination for PTAs; or
PTAs may also qualify if they are licensed, registered or certified as a PTA, if applicable and meet requirements in effect before January 1, 2008, that is,
they have graduated before January 1, 2008, from a 2 year college level program approved by the APTA; or

on or before December 31, 1977, they were licensed or qualified as a PTA and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Services. *The services of PTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising physical therapist. PTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws.*

A physical therapist must supervise PTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details. For example, in clinics, rehabilitation agencies, and public health agencies, 42CFR485.713 indicates that when a PTA provides services, either on or off the organization’s

premises, those services are supervised by a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation.

The services of a PTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

The cost of supplies (e.g., theraband, hand putty, electrodes) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the physical therapist, and are, therefore, not separately billable. Separate coverage and billing provisions apply to items that meet the definition of brace in §130.

Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services..

2. Practice of Occupational Therapy (230.2)

A. General

Occupational therapy services are those services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. (See Pub. 100-03, the Medicare National Coverage Determinations Manual, for specific conditions or services.)

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve:

The evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;

The selection and teaching of task-oriented therapeutic activities designed to restore physical function; e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns;

The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness; e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient;

The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function; e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image;

The teaching of compensatory technique to improve the level of independence in the activities of daily living, for example:

Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand;

Teaching an upper extremity amputee how to functionally utilize a prosthesis;

Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities as independently as possible; or

Teaching a patient with a hip fracture/hip replacement techniques of standing tolerance and balance to enable the patient to perform such functional activities as dressing and homemaking tasks.

The designing, fabricating, and fitting of orthotics and self-help devices; e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed independently; or

Vocational and prevocational assessment and training, subject to the limitations specified in item B below.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician/NPP a plan of treatment.

B. Qualified Occupational Therapist Defined

Reference: 42CFR484.4

Personnel Qualifications. *The new personnel qualifications for physical therapist assistants (PTA) were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.*

The regulation provides that a qualified PTA is a person who is licensed as a PTA unless licensure does not apply, is registered or certified, if applicable, as a PTA by the state in which practicing, and graduated from an approved curriculum for PTAs, and passed a national examination for PTAs. The phrase, "by the state in which practicing" includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location or the entity billing for the services. Approval for the curriculum is provided by CAPTE or, if internationally or military trained PTAs apply, approval will be through a credentialing body for the curriculum for PTAs identified by either the American Physical Therapy Association or identified in 8 CFR 212.15(e).

A national examination for PTAs is, for example the one furnished by the Federation of State Boards of Physical Therapy. These requirements above apply to all PTAs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010. Those PTAs also qualify who, on or before December 31, 2009, are licensed, registered or certified as a PTA and met one of the two following requirements:

Is licensed or otherwise regulated in the state in which practicing; or

In states that have no licensure or other regulations, or where licensure does not apply, PTAs have:

o graduated on or before December 31, 2009, from a 2-year college-level program approved by the APTA or CAPTE; and

o effective January 1, 2010, those PTAs must have both graduated from a CAPTE approved curriculum and passed a national examination for PTAs; or

PTAs may also qualify if they are licensed, registered or certified as a PTA, if applicable and meet requirements in effect before January 1, 2008, that is,

they have graduated before January 1, 2008, from a 2 year college level program approved by the APTA; or

on or before December 31, 1977, they were licensed or qualified as a PTA and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Services. The services of PTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising physical therapist. PTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws.

A physical therapist must supervise PTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details. For example, in clinics, rehabilitation agencies, and public health agencies, 42CFR485.713 indicates that when a PTA provides services, either on or off the organization's premises, those services are supervised by a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation.

The services of a PTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

The cost of supplies (e.g., theraband, hand putty, electrodes) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the physical therapist, and are, therefore, not separately billable. Separate coverage and billing provisions apply to items that meet the definition of brace in §130.

Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

***C. Services of Occupational Therapy Support Personnel**

Reference: 42CFR 484.4

The new personnel qualifications for occupational therapy assistants were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that an occupational therapy assistant is a person who is licensed, unless licensure does not apply, or otherwise regulated, if applicable, as an OTA by the state in which practicing, and graduated from an OTA education program accredited by ACOTE and is eligible to take or has successfully completed the NBCOT examination for OTAs. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services.

If the requirements above are not met, an OTA may qualify if, on or before December 31, 2009, the OTA is licensed or otherwise regulated as an OTA, if applicable, by the state in which practicing, or meets any qualifications defined by the state in which practicing.

Or, where licensure or other state regulation does not apply, OTAs may qualify if they have, on or before December 31, 2009:

completed certification requirements to practice as an OTA established by a credentialing organization approved by AOTA; and

after January 1, 2010, they have also completed an education program accredited by ACOTE and passed the NBCOT examination for OTAs.

OTAs who qualified under the policies in effect prior to January 1, 2008, continue to qualify to provide OT directed and supervised OTA services to Medicare beneficiaries. Therefore, OTAs qualify who after December 31, 1977, and on or before December 31, 2007:

completed certification requirements to practice as an OTA established by a credentialing organization approved by AOTA; or

completed the requirements to practice as an OTA applicable in the state in which practicing.

Those OTAs who were educated outside the U.S. may meet the same requirements as domestically trained OTAs. Or, if educated outside the U.S. on or after January 1, 2008, they must have graduated from an OTA program accredited as substantially equivalent to OTA entry level education in the U.S. by ACOTE, its successor organization, or the World Federation of Occupational Therapists or a credentialing body approved by AOTA. In addition, they must have passed an exam for OTAs administered by NBCOT.

Services. The services of OTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising occupational therapist. OTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating occupational therapist and in accordance with state laws.

An occupational therapist must supervise OTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for OTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details. For example, in clinics, rehabilitation agencies, and public health agencies, 42CFR485.713 indicates that when an OTA provides services, either on or off the organization’s premises, those services are supervised by a qualified occupational therapist who makes an

onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation.

The services of an OTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

The cost of supplies (e.g., looms, ceramic tiles, or leather) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the occupational therapist and are, therefore, not separately billable. Separate coverage and billing provisions apply to items that meet the definition of brace in §130 of this manual.

Services provided by aides, even if under the supervision of a therapist, are not therapy services in the outpatient setting and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

D. Application of Medicare Guidelines to Occupational Therapy Services

Occupational therapy may be required for a patient with a specific diagnosed psychiatric illness. If such services are required, they are covered assuming the coverage criteria are met. However, where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient. Patient motivation is an appropriate and inherent function of all health disciplines, which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist are not required, an occupational therapy program for individuals who do not have a specific diagnosed psychiatric illness is not to be considered reasonable and necessary for the treatment of an illness or injury. Services furnished under such a program are not covered.

Occupational therapy may include vocational and prevocational assessment and training. When services provided by an occupational therapist are related solely to specific employment opportunities, work skills, or work settings, they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are not covered. However, carriers and intermediaries exercise care in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and non-vocational purposes. For example, an assessment of sitting and standing tolerance might be non-vocational for a mother of young children or a retired individual living alone, but could also be a vocational test for a sales clerk. Training an amputee in the use of prosthesis for telephoning is necessary for everyday activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability. The techniques of adjustment cannot be considered exclusively vocational or non-vocational.

3. Practice of Speech-Language Pathology (230.3)

A. General

Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and

language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See Pub. 100-03, chapter 1, §170.3)

***B. Qualified Speech-Language Pathologist Defined**

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech-Language Hearing Association; or

Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

**For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.*

C. Services of Speech-Language Pathology Support Personnel

Services of speech-language pathology assistants are not recognized for Medicare coverage. Services provided by speech-language pathology assistants, even if they are licensed to provide services in their states, will be considered unskilled services and denied as not reasonable and necessary if they are billed as therapy services.

Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

***D. Application of Medicare Guidelines to Speech-Language Pathology Services**

1. Evaluation Services

Speech-language pathology evaluation services are covered if they are reasonable and necessary and not excluded as routine screening by §1862(a)(7) of the Act. The speech-language pathologist employs a variety of formal and informal speech, language, and dysphagia assessment tests to ascertain the type, causal factor(s), and severity of the speech and language or swallowing disorders. Reevaluation of patients for whom speech, language and swallowing were previously contraindicated is covered only if the patient exhibits a change in medical condition. However, monthly reevaluations; e.g., a Western Aphasia Battery, for a patient undergoing a rehabilitative speech-language pathology program, are considered a part of the treatment session and shall not be covered as a separate evaluation for billing purposes. Although hearing screening by the speech-language pathologist may be part of an evaluation, it is not billable as a separate service.

2. Therapeutic Services

The following are examples of common medical disorders and resulting communication deficits, which may necessitate active rehabilitative therapy. This list is not all-inclusive:

Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;

Neurological disease such as Parkinsonism or Multiple Sclerosis with dysarthria, dysphagia, inadequate respiratory volume/control, or voice disorder; or

Laryngeal carcinoma requiring laryngectomy resulting in aphonia.

***3. Impairments of the Auditory System**

The terms, aural rehabilitation, auditory rehabilitation, auditory processing, lipreading and speech reading are among the terms used to describe covered services related to perception and comprehension of sound through the auditory system. See Pub. 100-04, chapter 12, section 30.3 for billing instructions. For example:

Auditory processing evaluation and treatment may be covered and medically necessary. Examples include but are not limited to services for certain neurological impairments or the absence of natural auditory stimulation that results in impaired ability to process sound. Certain auditory processing disorders require diagnostic audiological tests in addition to speech-language pathology evaluation and treatment.

Evaluation and treatment for disorders of the auditory system may be covered and medically necessary, for example, when it has been determined by a speech-language pathologist in collaboration with an audiologist that the hearing impaired beneficiary's current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient's functional communication needs. Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologists may provide treatment.

Assessment for the need for rehabilitation of the auditory system (but not the vestibular system) may be done by a speech language pathologist. Examples include but are not limited to: evaluation of comprehension and production of language in oral, signed or written modalities, speech and voice production, listening skills, speech reading, communications strategies, and the impact of the hearing loss on the patient/client and family. Examples of rehabilitation include but are not limited to treatment that focuses on comprehension, and production of language in oral, signed or written modalities; speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training, communication strategies, education and counseling. In determining the necessity for treatment, the beneficiary's performance in both clinical and natural environment should be considered.

4. Dysphagia

Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death. It is most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathy. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment.

The speech-language pathologist performs clinical and instrumental assessments and analyzes and integrates the diagnostic information to determine candidacy for intervention as well as appropriate compensations and rehabilitative therapy techniques. The equipment that is used in the examination may be fixed, mobile or portable. Professional guidelines recommend that the service be provided in a team setting with a physician/NPP who provides supervision of the radiological examination and interpretation of medical conditions revealed in it.

Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques.

IX. Services Furnished by a Physical or Occupational Therapist in Private Practice (230.4)

A. General

In order to qualify to bill Medicare directly as a therapist, each individual must be enrolled as a private practitioner and employed in one of the following practice types: an unincorporated solo practice, unincorporated partnership, unincorporated group practice, physician/NPP group or groups that are not professional corporations, if allowed by state and local law. Physician/NPP group practices may employ physical therapists in private practice (PTPP) and/or occupational therapists in private practice (OTPP) if state and local law permits this employee relationship. For purposes of this provision, a physician/NPP group practice is defined as one or more physicians/NPPs enrolled with Medicare who may bill as one entity. For further details on issues concerning enrollment, see the provider enrollment Web site at www.cms.hhs.gov/providers/enrollment. Private practice also includes therapists who are practicing therapy as employees of another supplier, of a professional corporation or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of an institutional provider.

**When therapy services may be furnished appropriately in a community pool by a clinician in a physical therapist or occupational therapist private practice, physician office, outpatient hospital, or outpatient SNF, the practice/office or provider shall rent or lease the pool, or a specific portion of the pool. The use of that part of the pool during specified times shall be restricted to the patients of that practice or provider. The written agreement to rent or lease the pool shall be available for review on request. When part of the pool is rented or leased, the agreement shall describe the part of the pool that is used exclusively by the patients of that practice/office or provider and the times that exclusive use applies. Other providers, including providers of outpatient physical therapy and speech-language pathology (OPTs or rehabilitation agencies)*

and CORFs, are subject to the requirements outlined in the respective State Operations Manual regarding rented or leased community pools.

If therapists who have their own Medicare Personal Identification number (PIN) or National Provider Identifier (NPI) are employed by therapist groups, physician/NPP groups, or groups that are not professional organizations, the requirement that therapy space be owned, leased, or rented may be satisfied by the group that employs the therapist. Each physical or occupational therapist employed by a group should enroll as a PT or OT in private practice.

When therapists with a Medicare PIN/NPI provide services in the physician's/NPP's office in which they are employed, and bill using their PIN/NPI for each therapy service, then the direct supervision requirement for PTAs and OTAs apply.

When the PT or OT who has a Medicare PIN/ NPI is employed in a physician's/NPP's office the services are ordinarily billed as services of the PT or OT, with the PT or OT identified on the claim as the supplier of services. However, services of the PT or OT who has a Medicare PIN/NPI may also be billed by the physician/NPP as services incident to the physician's/NPP's service. (See §X for rules related to PTA and OTA services incident to a physician.) In that case, the physician/NPP is the supplier of service, the Unique Provider Identification Number (UPIN) or NPI of the physician/NPP (ordering or supervising, as indicated) is reported on the claim with the service and all the rules for incident to services (§X) must be followed.

B. Private Practice Defined

Reference: Federal Register November, 1998, pages 58863-58869; 42CFR 410.38(b)

The carrier considers a therapist to be in private practice if the therapist maintains office space at his or her own expense and furnishes services only in that space or the patient's home. Or, a therapist is employed by another supplier and furnishes services in facilities provided at the expense of that supplier.

The therapist need not be in full-time private practice but must be engaged in private practice on a regular basis; i.e., the therapist is recognized as a private practitioner and for that purpose has access to the necessary equipment to provide an adequate program of therapy.

The physical or occupational therapy services must be provided either by or under the direct supervision of the therapist in private practice. Each physical or occupational therapist in a practice should be enrolled as a Medicare provider. If a physical or occupational therapist is not enrolled, the services of that therapist must be directly supervised by an enrolled physical or occupational therapist. Direct supervision requires that the supervising private practice therapist be present in the office suite at the time the service is performed. These direct supervision requirements apply only in the private practice setting and only for physical therapists and occupational therapists and their assistants. In other outpatient settings, supervision rules differ.

The services of support personnel must be included in the therapist's bill. The supporting personnel, including other therapists, must be W-2 or 1099 employees of the therapist in private practice or other qualified employer.

Coverage of outpatient physical therapy and occupational therapy under Part B includes the services of a qualified therapist in private practice when furnished in the therapist's office or the beneficiary's home. For this purpose, "home" includes an institution that is used as a home, but

not a hospital, CAH or SNF, (Federal Register Nov. 2, 1998, pg 58869). Place of Service (POS) includes:

- 03 School, only if residential,
- 04 Homeless Shelter,
- 12 Home, other than a facility that is a private residence,
- 14 Group Home,
- 33 Custodial Care Facility.

C. Assignment

Reference: Nov. 2, 1998 Federal Register, pg. 58863; See also Pub. 100-04 chapter 1, 30.2.

When physicians, NPPs, PTPPs or OTPPs obtain provider numbers, they have the option of accepting assignment (participating) or not accepting assignment (nonparticipating). In contrast, providers, such as outpatient hospitals, SNFs, rehabilitation agencies, and CORFs, do not have the option. For these providers, assignment is mandatory.

If physicians/NPPs, PTPPs or OTPPs accept assignment (are participating), they must accept the Medicare Physician Fee Schedule amount as payment. Medicare pays 80% and the patient is responsible for 20%. In contrast, if they do not accept assignment, Medicare will only pay 95% of the fee schedule amount. However, when these services are not furnished on an assignment-related basis, the limiting charge applies. (See §1848(g)(2)(c) of the Act.)

NOTE: Services furnished by a therapist in the therapist's office under arrangements with hospitals in rural communities and public health agencies (or services provided in the beneficiary's home under arrangements with a provider of outpatient physical or occupational therapy services) are not covered under this provision. See section XI.

X. Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and NPPs (230.5)

References: §1861(s)(2)(A) of the Act; 42 CFR 410.10(b); 42 CFR 410.26; Pub.100-02, ch. 15, § 60.

The Benefit. Therapy services have their own benefit under §1861 of the Social Security Act and shall be covered when provided according to the standards and conditions of the benefit described in Medicare manuals. The statute 1862(a)(20) requires that payment be made for a therapy service billed by a physician/NPP only if the service meets the standards and conditions--other than licensing--that would apply to a therapist. (For example, see coverage requirements in Pub. 100-08, chapter 13, §13.5.1(C), Pub. 100-04, chapter 5, and also the requirements in this policy.

Incident to a Therapist. There is no coverage for services provided incident to the services of a therapist. Although PTAs and OTAs work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services incident to a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist's service.

Qualifications of Auxiliary Personnel. Therapy services appropriately billed incident to a physician's/NPP's service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting with one exception. When therapy services are performed incident to a physician's/NPP's service, the qualified personnel who perform the

service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. Qualifications for therapists are found in 42CFR484.4 and in section VIII.1.2.3. of this policy. In effect, these rules require that the person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above. Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

The services of PTAs and OTAs also may not be billed incident to a physician's/NPP's service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, when directly supervised by the PT or the services of the OTA, when directly supervised by the OT may be billed by the physician group as PT or OT services using the PIN/NPI of the enrolled PT (or OT). (See Section X for private practice rules on billing services performed in a physician's office.) If the PT or OT is not enrolled, Medicare shall not pay for the services of a PTA or OTA billed incident to the physician's service, because they do not meet the qualification standards in 42CFR484.4.

Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements. (See Pub100-2 Ch. 15, §60). Where the policies have different requirements, the more stringent requirement shall be met.

For example, when therapy services are billed as incident to a physician/NPP services, the requirement for direct supervision by the physician/NPP and other incident to requirements must be met, even though the service is provided by a licensed therapist who may perform the services unsupervised in other settings.

The mandatory assignment provision does not apply to therapy services furnished by a physician/NPP or "incident to" a physician's/NPP's service. However, when these services are not furnished on an assignment-related basis; the limiting charge applies.

For emphasis, following are some of the standards that apply to therapy services billed incident-to the services of a physician/NPP in the physician's/NPP's office or the beneficiary's residence.

- 1. Therapy services provided to the beneficiary must be covered and payable outpatient rehabilitation services as described, for example, in this section as well as Pub. 100-08, chapter 13, §13.5.1.*
- 2. Therapy services must be provided by, or under the direct supervision of a physician (a doctor of medicine or osteopathy) or NPP who is legally authorized to practice therapy services by the state in which he or she performs such function or action. Direct supervision requirements are the same as in 42CFR410.32(b)(3). The supervisor must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician/NPP must be present in the same room in the office where the service is performed.*
- 3. The services must be of a level of complexity that require that they be performed by a therapist or under the direct supervision of the therapist, physician/NPP who is licensed to perform them. Services that do not require the performance or*

supervision of the therapist, physician/NPP, are not considered reasonable or necessary therapy services even if they are performed or supervised by a physician/NPP or other qualified professional.

4. *Services must be furnished under a plan of treatment as in §IV of this policy. The services provided must relate directly to the physician/NPP service to which it is incident*

XI. Therapy Services Furnished Under Arrangements With Providers and Clinics (230.6)

Deleted: See CMS Pub.100-02, chapter 15, §230.6.

XII. Applicable Outpatient Rehabilitation HCPCS Codes (CP Ch.5 §20.B)

<http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf>

The CMS identifies the following codes as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech-language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology. Check the notes below the chart for details about each code.

When in effect, any financial limitation will also apply to services represented by the following codes, except as noted below.

NOTE: Listing of the following codes does not imply that services are covered or applicable to all provider settings.

<u>64550+</u>	<u>90901+</u>	<u>92506A</u>	<u>92507A</u>	<u>92508</u>	<u>92526</u>
<u>92597</u>	<u>92605****</u>	<u>92606****</u>	<u>92607</u>	<u>92608</u>	<u>92609</u>
<u>92610+</u>	<u>92611+</u>	<u>92612+</u>	<u>92614+</u>	<u>92616+</u>	<u>95831+</u>
<u>95832+</u>	<u>95833+</u>	<u>95834+</u>	<u>95851+</u>	<u>95852+</u>	<u>96105+</u>
<u>96110+√</u>	<u>96111+√</u>	<u>97001</u>	<u>97002</u>	<u>97003</u>	<u>97004</u>
<u>97010****</u>	<u>97012</u>	<u>97016</u>	<u>97018</u>	<u>97022</u>	<u>97024</u>
<u>97026</u>	<u>97028</u>	<u>97032</u>	<u>97033</u>	<u>97034</u>	<u>97035</u>
<u>97036</u>	<u>97039*∅</u>	<u>97110</u>	<u>97112</u>	<u>97113</u>	<u>97116</u>
<u>97124</u>	<u>*96125</u>	<u>97139*∅</u>	<u>97140</u>	<u>97150</u>	<u>97530</u>
<u>97532+</u>	<u>97533</u>	<u>97535</u>	<u>97537</u>	<u>97542</u>	<u>97597+ε</u>
<u>97598+ε</u>	<u>97602+ε****</u>	<u>97605+ε</u>	<u>97606+ε</u>	<u>97750</u>	<u>97755</u>
<u>97760**Δ</u>	<u>97761</u>	<u>97762</u>	<u>97799*</u>	<u>G0281</u>	<u>G0283</u>

<u>G0329</u>	0019T+***	0029T+***			
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* The physician fee schedule abstract file does not contain a price for CPT codes 97039, 97139, or 97799, since the carrier prices them. Therefore, the FI must contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

◇ Effective January 1, 2006, these codes will no longer be valued under the MPFS. They will be priced by the carriers.

Δ Effective January 1, 2006, the code descriptors for these services have been changed.

** CPT code 97760 should not be reported with CPT code 97116 for the same extremity.

*** The physician fee schedule abstract file does not contain a price for CPT codes 0019T or 0029T since they are priced by the carrier. In addition, the carrier determines coverage for these codes. Therefore, the FI contacts the carrier to obtain the appropriate fee schedule amount.

**** These HCPCS/CPT codes are bundled under the MPFS. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, never make payment separately for these codes. If billed alone, HCPCS/CPT codes marked as

“*****” shall be denied using the existing MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97 that says: “Payment is included in the allowance for another service/procedure.” Use reason code 97 to deny a procedure code that should have been bundled. Alternatively, reason code B15, which has the same intent, may also be used.

√ If billed by an outpatient hospital department, these HCPCS codes are paid using the Outpatient Prospective Payment System (OPPS).

Underlined codes are “always therapy” services, regardless of who performs them. These codes always require therapy modifiers (GP, GO, GN).

ξ If billed by a hospital subject to OPPS for an outpatient service, these HCPCS codes—also indicated as “sometimes therapy” services - will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. The requirements for other “sometimes therapy” codes, described below, apply.

+ These HCPCS/CPT codes sometimes represent therapy services. However, these codes always represent therapy services and require the use of a therapy modifier when performed by therapists.

There are some circumstances when these codes will not be considered representative of therapy services and therapy limits (when they are in effect) will not apply. Codes marked + are not therapy services when:

It is not appropriate to bill the service under a therapy plan of care, and

They are billed by practitioners/providers of services who are not therapists, i.e.,

physicians, clinical nurse specialists, nurse practitioners and psychologists; or they are billed to fiscal intermediaries by hospitals for outpatient services which are performed by non-therapists as noted in Note 8" above.

While the "+" designates that a particular HCPCS/CPT code will not of itself always indicate that a therapy service was rendered, these codes always represent therapy services when rendered by therapists or by practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. For these situations, these codes must always have a therapy modifier. For example, when the service is rendered by either a doctor of medicine or a nurse practitioner (acting within the scope of his or her license when performing such service), with the goal of rehabilitation, a modifier is required. When there is doubt about whether a service should be part of a therapy plan of care, the contractor shall make that determination.

"Outpatient rehabilitation therapy" refers to skilled therapy services, requiring the skills of qualified therapists, performed for restorative purposes and generally involving ongoing treatments as part of a therapy plan of care. In contrast, a non-therapy service is a service performed by non-therapist practitioners, without an appropriate rehabilitative plan or goals, e.g., application of a surface (transcutaneous) neurostimulator – CPT code 64550, and biofeedback training by any modality – CPT code 90901. When performed by therapists, these are "always" therapy services. Contractors have discretion to determine whether circumstances describe a therapy service or require a rehabilitation plan of care.

The underlined HCPCS codes on the above list do not have a + sign because they are considered "always therapy" codes and always require a therapy modifier. Therapy services, whether represented by "always therapy" codes, or + codes in the above list performed as outpatient rehabilitation therapy services, must follow all the policies for therapy services (e.g., Pub. 100-04, chapter 5; Pub. 100-02, chapters 12 and 15).

XIII. Counting Minutes for Timed Codes in 15 Minute Units (CP Ch.5 §20.2C)
<http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> (Page 35)

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

<i>Units</i>	<i>Number of Minutes</i>
<i>1 unit:</i>	<i>≥ 8 minutes through 22 minutes</i>
<i>2 units:</i>	<i>≥ 23 minutes through 37 minutes</i>
<i>3 units:</i>	<i>≥ 38 minutes through 52 minutes</i>
<i>4 units:</i>	<i>≥ 53 minutes through 67 minutes</i>
<i>5 units:</i>	<i>≥ 68 minutes through 82 minutes</i>
<i>6 units:</i>	<i>≥ 83 minutes through 97 minutes</i>
<i>7 units:</i>	<i>≥ 98 minutes through 112 minutes</i>
<i>8 units:</i>	<i>≥ 113 minutes through 127 minutes</i>

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Documentation Requirements indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1 -

*24 minutes of neuromuscular reeducation, code 97112,
23 minutes of therapeutic exercise, code 97110,
Total timed code treatment time was 47 minutes.*

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

Example 2 -

*20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110),
40 Total timed code minutes.*

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3

33 minutes of therapeutic exercise (97110),
 7 minutes of manual therapy (97140),
 40 Total timed minutes

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –

18 minutes of therapeutic exercise (97110),
 13 minutes of manual therapy (97140),
 10 minutes of gait training (97116),
 8 minutes of ultrasound (97035),
 49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5 –

7 minutes of neuromuscular reeducation (97112)
 7 minutes therapeutic exercise (97110)
 7 minutes manual therapy (97140)
 21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See Indications and Limitations of Coverage §I) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes-- including minutes spent providing services represented by untimed codes— are also documented. For documentation in the medical record of the services provided see Documentation Requirements

XIV. Specific Limits for HCPCS (CP Ch5 §20.2 D)

(<http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> Page 37)

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called “always therapy” must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

- a. The codes that are allowed one unit for “Allowed Units” in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.*
- b. The codes allowed 0 units in the column for “Allowed Units”, may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).*
- c. When physicians/NPPs bill “always therapy” codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an “always therapy” code unless the service is provided under a therapy plan of care. Therefore, NA stands for “Not Applicable” in the chart below.*
- d. When a “sometimes therapy” code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.*

<i>HCPCS</i>	<i>Code Description and Claim Line Outlier/Edit Details</i>	<i>Timed or Untimed</i>	<i>PT Allowed units</i>	<i>OT Allowed units</i>	<i>SLP Allowed units</i>	<i>Physician/NPPN OT under Therapy POC</i>
92506	Speech/hearing evaluation	Untimed	0	0	1	NA
92597	Oral speech device eval	Untimed	0	1	1	NA
92607	Ex for speech device rx, 1hr	Timed	0	1	1	NA
92611	Motion fluoroscopy/swallow	Untimed	0	1	1	1
92612	Endoscope swallow test (fees)	Untimed	0	1	1	1
92614	Laryngoscopic sensory test	Untimed	0	1	1	1

92616	<i>Fees w/laryngeal sense test</i>	<i>Untimed</i>	<i>0</i>	<i>1</i>	<i>1</i>	<i>1</i>
95833	<i>Limb muscle testing, manual</i>	<i>Untimed</i>	<i>1</i>	<i>1</i>	<i>0</i>	<i>1</i>
95834	<i>Limb muscle testing, manual</i>	<i>Untimed</i>	<i>1</i>	<i>1</i>	<i>0</i>	<i>1</i>
96110	<i>Developmental test, lim</i>	<i>Untimed</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>
96111	<i>Developmental test, extend</i>	<i>Untimed</i>	<i>1</i>	<i>1</i>	<i>1</i>	<i>1</i>
97001	<i>PT evaluation</i>	<i>Untimed</i>	<i>1</i>	<i>0</i>	<i>0</i>	<i>NA</i>
97002	<i>PT re-evaluation</i>	<i>Untimed</i>	<i>1</i>	<i>0</i>	<i>0</i>	<i>NA</i>
97003	<i>OT evaluation</i>	<i>Untimed</i>	<i>0</i>	<i>1</i>	<i>0</i>	<i>NA</i>
97004	<i>OT re-evaluation</i>	<i>Untimed</i>	<i>0</i>	<i>1</i>	<i>0</i>	<i>NA</i>

*Coverage Topic**Physical, Occupational, Speech Therapy**Coding Information**Modifiers**GN - Service Delivered Under An Outpatient Speech-Language Pathology Plan of Care**GO - Service Delivered Under An Outpatient Occupational Therapy Plan of Care**GP - Service Delivered Under An Outpatient Physical Therapy Plan of Care****KX - Specific Required Documentation on File******A. General***

- 1. List the appropriate procedure code for the services performed, including any necessary modifiers and appropriate quantities in the days/units field. (See 07/2003 Communiqué pg.76 for OP rehab. modifiers)*
 - a. PT/OT/SPL services personally performed by a qualified physician/NPP in their office location or a beneficiary's home should be reported to Medicare under the physicians/NPPs Medicare PIN, with an appropriate HCPCS/CPT code and the appropriate therapy modifier (GN, GO, GP).*
 - b. PT/OT/SPL services performed, by a qualified therapist without a Medicare PIN employed by a physician/NPP or physician/NPP group should be reported to Medicare under the physicians/NPPs Medicare PIN, with an appropriate HCPCS/CPT code and the appropriate therapy modifier (GN, GO, GP). These services must be performed under the physicians/NPP direct supervision in the office or under the direct personal supervision in a beneficiary's home*

- c. *PT/OT services, performed by a qualified therapist in independent practice or employed by a physician/NPP or physician/NPP group with a Medicare PIN, should be reported to Medicare under the therapists Medicare PIN, with an appropriate HCPCS/CPT code and the appropriate therapy modifier (GN, GO, GP).*
- d. *A KX modifier should be reported on a claim identified as therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved or the guidelines for an automatic exception is met and the therapy cap is exceeded. Do not apply the KX modifier to therapy service claims unless the therapy cap is exceeded and therapy cap exceptions are met.*
- 2. *Multiple procedure CPT codes in the PM&R range are quantity processed services. The 15-minute time interval listed in the code description represents a quantity of one. Each additional 15 minutes should be reported with an additional quantity number in the quantity in the quantity/units field on the claim form. (e.g. report 30 minutes as 0020, an hour as 0040) (See §XIII)*
- 3. *Report the patient's diagnosis or condition with an ICD-9 code. The ICD-9 code should be coded to the highest level of specificity.*
 - a. *Report the patients specific condition for which the current therapy episode of care services are being performed, in the first position in Item 21 of the CMS 1500 claim form or electronic equivalent field.*
 - b. *Report existing conditions, complexities or circumstances influencing the length or intensity of the current therapy episode of care in the remaining positions.*
- 4. *Services submitted without an ICD-9 diagnosis code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.*
- 5. *It is understood that any diagnosis information submitted must have (in the patient record) medical justification for the procedure. Subsequent determination that the medical record is lacking such justification will result in a retroactive denial under Section 1862(a)(1)(A).*
- 6. *When billing for services, requested by the beneficiary for denial, that would be considered not reasonable and necessary (See denial Summary - Medical Necessity 1-6), report ICD-9 code V57.9-unspecified rehabilitation procedure and the GA modifier (waiver of liability on file) if an ABN signed by the beneficiary is on file or the GZ modifier (items or services expected to be denied as not reasonable) when a signed ABN for the service is not on file.*
- B. *Physical Therapy (PT), Occupational Therapy (OT) and Speech Language Pathology (SPL)***
 - 1. *Services provided in outpatient/inpatients hospitals or skilled nursing facilities (Part A) are not covered by Medicare Part B.*
 - 2. *Physical/occupational and speech-language pathology therapy services that, when rendered to a beneficiary in a non-Part A covered stay (i.e., Part A benefits exhausted), are included in Consolidated Billing and may not be submitted to the carrier (Part B) for payment. They must be submitted to the SNF for payment.*
 - 3. *If services are provided in the above facilities, providers of PT, OT and SPL should NOT submit claims to Medicare Part B.*
 - 4. *Refer to Durable Medical Equipment Regional Carriers (DMERC) for services billable to them.*
 - 5. *Speech pathologists cannot bill for their services directly.*

6. CPT codes 92506-92508 are used to report a single encounter regardless of the duration of the service on a given day. Place a "1" in Item 24G (units of service) box on the CMS-1500 form or the electronic equivalent.

Coding Table Information

Procedure Codes

90901, 92506-92508, 92520, 92526, 92597, 92607-92612, 92614, 92616, 95831-95834, 95851, 95852, 96105, 96110, 96111, 96125, 97001-97004, 97012, 97016, 97018, 97022-97028, 97032-97039, 97110-97150, 97530-97533, 97535, 97537, 97542, 97597, 97598, 97602, 97605, 97606, 97750, 97755, 97760-97762, 97799, G0281, G0283, G0329

Other codes not on the above list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service).

However, when these services are provided by therapists or as an integral part of a therapy plan of care, the CPT code must be accompanied with the appropriate therapy modifier.

NOTE: The above list of HCPCS/CPT codes are intended to facilitate the contractor's ability to pay claims under the MPFS. It is not intended to be an exhaustive list of covered services, imply applicability to provider setting, and does not assure coverage of these services.

ICD-9 Codes that DO NOT Support Medical Necessity
V57.9

Other Information

Documentation Requirements

1. Physician's Services must be submitted with an ICD-9 code to support medical necessity and must be coded to the greatest degree of accuracy and highest level of digit completeness. This means the precise ICD-9 code that most fully explains the narrative description of the diagnosis contained in the patient's medical record and reported including the 4th or 5th digit sub classification for the diagnosis category. In the absence of signs, symptoms, illness or injury a screening diagnosis should be reported, and payment will be denied.

2. Documentation Requirements for Therapy Services (220.3)

A. General

Therapy services shall be payable when the medical record and the information on the claim form consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to the requirements in Medicare manuals. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all legal/regulatory requirements applicable to Medicare claims.

The documentation guidelines in the Indications and Limitations of Coverage section of this policy identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. State or local laws and policies, or the policies of the profession, the practice, or the facility may be more stringent. Additional documentation not required by Medicare is encouraged when it

conforms to state or local law or to professional guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language Hearing Association. It is encouraged but not required that narratives that specifically justify the medical necessity of services be included in order to support approval when those services are reviewed. (See also section VII Reasonable and Necessary outpatient Rehabilitation Services)

Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

B. Documentation Required

List of Required Documentation. These types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise. The timelines are minimum requirements for Medicare payment. Document as often as the clinician's judgment dictates but no less than the frequency required in Medicare policy:

1. Evaluation /and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;
- *2. Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due.
- *3. Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due. (See definitions in section 220 and descriptions in 220.3 D);
4. Treatment Notes for each treatment day (may also serve as Progress Reports when required information is included in the notes); and
5. A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated, A separate statement is not required if the record justifies treatment without further explanation.

Limits on Requirements. Contractors shall not require more specific documentation unless other Medicare manual policies require it. Contractors may request further information to be included in these documents concerning specific cases under review when that information is relevant, but not submitted with records.

Dictated Documentation. For Medicare purposes, dictated therapy documentation is considered completed on the day it was dictated. The qualified professional may edit and electronically sign the documentation at a later date.

Dates for Documentation. The date the documentation was made is important only to establish the date of the initial plan of care because therapy cannot begin until the plan is established unless treatment is performed or supervised by the same clinician who establishes the plan. However,

contractors may require that treatment notes and progress reports be entered into the record within 1 ~~one~~ week of the last date to which the Progress Report or Treatment Note refers. For example, if treatment began on the first of the month at a frequency of twice a week, a Progress Report would be required at the end of the month. Contractors may require that the Progress Report that describes that month of treatment be dated not more than 1 ~~one~~ week after the end of the month described in the report.

Document Information to Meet Requirements. In documenting records, clinicians must be familiar with the requirements for covered and payable outpatient therapy services as described in the manuals. For example, the records should justify:

1. The patient is under the care of a physician/NPP;
 - a. Physician/NPP care shall be documented by physician/NPP certification (approval) of the plan of care; and
 - *b. Although not required, other evidence of physician/NPP involvement in the patient's care may include, for example: order/referral, conference, team meeting notes, and correspondence.
2. Services require the skills of a therapist.
 - a. Services must not only be provided by the qualified professional or qualified personnel, but they must require, for example, the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently. A clinician may not merely supervise, but must apply the skills of a therapist by actively participating in the treatment of a patient during each Progress Report Period. In addition, a therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.
 - b. A therapist's skill may also be required for safety reasons, if an unstable fracture requires the skill of a therapist to do an activity that might otherwise be done independently by the patient at home. Or the skill of a therapist might be required for a patient learning compensatory swallowing techniques to perform cervical auscultation and identify changes in voice and breathing that might signal aspiration. After the patient is judged safe for independent use of these compensatory techniques, the skill of a therapist is not required to feed the patient, or check what was consumed.
3. Services are of appropriate type, frequency, intensity and duration for the individual needs of the patient.
 - a. Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.
 - b. Clinicians and contractors shall determine typical services using published professional literature and professional guidelines. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Services that exceed those typically billed should be carefully documented to justify their necessity, but are payable if the individual patient benefits from medically necessary services. Also, some services or episodes of treatment should be less than those typically billed, when the individual patient reaches goals sooner than is typical.

- c. Documentation should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can happen during treatment. It is recommended that the reasons for lack of progress be noted and the justification for continued treatment be documented if treatment continues after regression or plateaus.

Needs of the Patient. When a service is reasonable and necessary, the patient also needs the services. Contractors determine the patient's needs through knowledge of the individual patient's condition, and any complexities that impact that condition, as described in documentation (usually in the evaluation, re-evaluation, and Progress Report). Factors that contribute to need vary, but in general they relate to such factors as the patient's diagnoses, complicating factors, age, severity, time since onset/acuity, self-efficacy/motivation, cognitive ability, prognosis, and/or medical, psychological and social stability. Patients who need therapy generally respond to therapy, so changes in objective and sometimes to subjective measures of improvement also help establish the need for services. The use of scientific evidence, obtained from professional literature, and sequential measurements of the patient's condition during treatment is encouraged to support the potential for continued improvement that may justify the patients need for therapy.

C. Evaluation/Re-Evaluation and Plan of Care

The initial evaluation, or the plan of care including an evaluation, should document the necessity for a course of therapy through objective findings and subjective patient self-reporting. Utilize the guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language and Hearing Association as guidelines, and not as policy. Only a clinician may perform an initial examination, evaluation, re-evaluation and assessment or establish a diagnosis or a plan of care. A clinician may include, as part of the evaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others.

Documentation of the evaluation should list the conditions and complexities and, where it is not obvious, describe the impact of the conditions and complexities on the prognosis and/or the plan for treatment such that it is clear to the contractor who may review the record that the services planned are appropriate for the individual.

Evaluation shall include:

1. A diagnosis (where allowed by state and local law) and description of the specific problem(s) to be evaluated and/or treated. The diagnosis should be specific and as relevant to the problem to be treated as possible. In many cases, both a medical diagnosis (obtained from a physician/NPP) and an impairment based treatment diagnosis related to treatment are relevant. The treatment diagnosis may or may not be identified by the therapist, depending on their scope of practice. Where a diagnosis is not allowed, use a condition description similar to the appropriate ICD-9 code. For example the medical diagnosis made by the physician is CVA; however, the treatment diagnosis or condition description for PT may be abnormality of gait, for OT, it may be hemiparesis, and for SLP, it may be dysphagia. For PT and OT, be sure to include the body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;
2. Results of one of the following four measurement instruments are recommended, but not required:

- a. National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association
 - b. Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO)
 - c. Activity Measure – Post Acute Care (AM-PAC)
 - d. OPTIMAL by Cedaron through the American Physical Therapy Association
3. If results of one of the four instruments above is not recorded, the record shall contain instead the following information indicated by plus signs (+) and should contain (but is not required to contain) all of the following, as applicable. Since published research supports its impact on the need for treatment, information in the following indented bullets may also be included with the results of the above four instruments in the evaluation report at the clinician’s discretion. This information may be incorporated into a test instrument or separately reported within the required documentation. If it changes, update this information in the re-evaluation, and/or Treatment Notes, and/or Progress Reports, and/or in a separate record. When it is provided, contractors shall take this documented information into account to determine whether services are reasonable and necessary.
- +4 Documentation supporting illness severity or complexity including, e.g.,
- +a. Identification of other health services concurrently being provided for this condition (e.g., physician, PT, OT, SLP, chiropractic, nurse, respiratory therapy, social services, psychology, nutritional/dietetic services, radiation therapy, chemotherapy, etc.), and/ or
 - +b. Identification of durable medical equipment needed for this condition, and/or
 - +c. Identification of the number of medications the beneficiary is taking (and type if known); and/or
 - +d. If complicating factors (complexities) affect treatment, describe why or how. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but in some patients such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception to caps for necessary services. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient’s condition as reported on a functional measurement tool may be so great as to suggest extended treatment is anticipated; and/or
 - +e. Generalized or multiple conditions. The beneficiary has, in addition to the primary condition being treated, another disease or condition being treated, or generalized musculoskeletal conditions, or conditions affecting multiple sites and these conditions will directly and significantly impact the rate of recovery; and/or.
 - +f. Mental or cognitive disorder. The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery; and/or.
 - +g. Identification of factors that impact severity including e.g., age, time since onset, cause of the condition, stability of symptoms, how typical/atypical are the symptoms of the diagnosed condition, availability of an intervention/treatment known to be effective, predictability of progress.
5. Documentation supporting medical care prior to the current episode, if any, (or document none) including, e.g.,
- a. Record of discharge from a Part A qualifying inpatient, SNF, or home health episode within 30 days of the onset of this outpatient therapy episode, or

- b. Identification of whether beneficiary was treated for this same condition previously by the same therapy discipline (regardless of where prior services were furnished; and
 - c. Record of a previous episode of therapy treatment from the same or different therapy discipline in the past year.
6. Documentation required to indicate beneficiary health related to quality of life, specifically,
 - a. The beneficiary's response to the following question of self-related health: "At the present time, would you say that your health is excellent, very good, fair, or poor?" If the beneficiary is unable to respond, indicate why; and
7. Documentation required to indicate beneficiary social support including, specifically,
 - a. Where does the beneficiary live (or intend to live) at the conclusion of this outpatient therapy episode? (e.g., private home, private apartment, rented room, group home, board and care apartment, assisted living, SNF), and
 - b. Who does beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode? (e.g., lives alone, spouse/significant other, child/children, other relative, un related person(s), personal care attendant), and
 - c. Does the beneficiary require this outpatient therapy plan of care in order to return to a premorbid (or reside in a new) living environment, and
 - d. Does the beneficiary require this outpatient therapy plan of care in order to reduce Activities of Daily Living (ADL) or Instrumental Activities of Daily Living or (IADL) assistance to a premorbid level or to reside in a new level of living environment (document prior level of independence and current assistance needs); and
8. Documentation required to indicate objective, measurable beneficiary physical function including, e.g.,
 - a. Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
 - b. Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
 - c. Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.
9. Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and
10. A determination that treatment is not needed, or, if treatment is needed a prognosis for return to premorbid condition or maximum expected condition with expected time frame and a plan of care.

NOTE: When the Evaluation Services as the Plan of Care. When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, intensity and duration of treatment are implied in the diagnosis and one-time service.

The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. A referral/order dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient.

The time spent in evaluation shall not also be billed as treatment time. Evaluation minutes are untimed and are part of the total treatment minutes, but minutes of evaluation shall not be included in the minutes for timed codes reported in the treatment notes.

Re-evaluations shall be included in the documentation sent to contractors when a re-evaluation has been performed. See the definition in § I. Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, for the use of the physician or the treatment site at which treatment will be continued.

A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation. The minutes for re-evaluation are documented in the same manner as the minutes for evaluation. Current Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code.

Plan of Care. See §IV for requirements of the plan. The evaluation and plan may be reported in two separate documents or a single combined document.

D. Progress Report

The Progress Report provides justification for the medical necessity of treatment. Contractors shall determine the necessity of services based on the delivery of services as anticipated in the plan and as documented in the Treatment Notes and Progress Report. For Medicare payment purposes, information required in Progress Reports shall be written by a clinician that is, either the physician/NPP who provides or supervises the services, or by the therapist who provides the services or supervises an assistant. It is not required that the referring or supervising physician/NPP sign the Progress Reports written by a PT, OT or SLP.

**Timing. The minimum Progress Report Period shall be at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation or treatment. Regardless of the date on which the report is actually written (and dated), the end of the Progress Report Period is either a*

date chosen by the clinician, the 10th treatment day, or the 30th calendar day of the episode of treatment, whichever is shorter. The next treatment day begins the next reporting period. The Progress Report Period requirements are complete when both the elements of the Progress Report and the clinician's active participation in treatment have been documented.

For example, for a patient evaluated on Monday, October 1 and being treated five times a week, on weekdays: On October 5, (before it is required), the clinician may choose to write a Progress Report for the last week's treatment (from October 1 to October 5). October 5 ends the reporting period and the next treatment on Monday, October 8 begins the next reporting period. If the clinician does not choose to write a report for the next week, the next report is required to cover October 8 through October 19, which would be 10 treatment days.

**It should be emphasized that the dates for recertification of plans of care do not affect the dates for required Progress Reports. (Consideration of the case in preparation for a report may lead the therapist to request early recertification. However, each report does not require recertification of the plan, and there may be several reports between recertifications). In many settings, weekly Progress Reports are voluntarily prepared to review progress, describe the skilled treatment, update goals, and inform physician/NPPs or other staff. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary. Particularly where the patient's medical status, or appropriate tapering of frequency due to expected progress towards goals, results in limited frequency e.g., (2-4 times a month), more frequent Progress Reports can differentiate rehabilitative from maintenance treatment, document progress and justify the continued necessity for skilled care.*

**Absences: Holidays, sick days or other patient absences may fall within the Progress Report Period. Days on which a patient does not encounter qualified professional or qualified personnel, for treatment, evaluation or re-evaluation do not count as treatment days. However, absences do not affect the requirement for a Progress Report at least once during each Progress Report Period certification interval. If the patient is absent unexpectedly at the end of the reporting period, when the clinician has not yet provided the required active participation during that reporting period, a Progress Report is still required, but without the clinician's active participation in treatment, the requirements of the Progress Report Period are incomplete.*

**Delayed Reports: If the clinician has not written a Progress Report before the end of the Progress Reporting Period, it shall be written within 7 calendar days after of the end of the reporting period. If the clinician did not participate actively in treatment during the Progress Report Period, documentation of the delayed active participation shall be entered in the Treatment Note as soon as possible. The Treatment Note shall explain the reason for the clinician's missed active participation. Also, the Treatment Note shall document the clinician's guidance to the assistant or qualified personnel to justify that the skills of a therapist were required during the reporting period. It is not necessary to include in this Treatment Note any information already recorded in prior Treatment Notes or Progress Reports.*

The contractor shall make a clinical judgment whether continued treatment by assistants or qualified personnel is reasonable and necessary when the clinician has not actively participated in treatment for longer than one reporting period. Judgment shall be based on the individual case and documentation of the application of the clinician's skills to guide the assistant or qualified personnel during and after the reporting period.

Early Reports: Often, Progress Reports are written weekly, or even daily, at the discretion of the clinician. Clinicians are encouraged, but not required to write Progress Reports more frequently than the minimum required in order to allow anyone who reviews the records to easily determine that the services provided are appropriate, covered and payable.

**Elements of Progress Reports may be written in the Treatment Notes if the provider/supplier or clinician prefers. If each element required in a Progress Report is included in the Treatment Notes at least once during the Progress Report Period, then a separate Progress Report is not required. Also, elements of the Progress Report may be incorporated into a revised Plan of Care when one is indicated. Although the Progress Report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the Plan of Care accompanied by the Progress Report shall be re-certified by a physician/NPP. See the section 220.1.2C on Plan of Care for guidance on when a revised plan requires certification.*

Progress Reports for Services Billed Incident to a Physician's Service. The policy for incident to services requires, for example, the physician's initial service, direct supervision of therapy services, and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment (See section 60.1B of CMS Pub.100-2 Ch.15). Also, see the billing requirements for services incident to a physician in Pub.100-04, chapter 26, Items 17, 19, 24, and 31.) Therefore, supervision and reporting requirements for supervising physician/NPPs supervising staff are the same as those for PTs and OTs supervising PTAs and OTAs with certain exceptions noted below.

When a therapy service is provided by a therapist, supervised by a physician/NPP and billed incident to the services of the physician/NPP, the progress report shall be written and signed by the therapist who provides the services.

When the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.

Documenting Clinician Participation in Treatment in the Progress Report: Verification of the clinician's required participation in treatment during the Progress Report Period shall be documented by the clinician's signature on the Treatment Note and/or on the Progress Report. When unexpected discontinuation of treatment occurs, contractors shall not require a clinician's participation in treatment for the incomplete reporting period.

**The Discharge (or Discharge Summary) is required for each episode outpatient of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The Discharge Note shall be a Progress Report written by a clinician, and shall cover the reporting period from the last Progress Report to the date of discharge. In the case of a discharge unanticipated in the plan or previous Progress Report, the clinician may base any judgments required to write the report on the Treatment Notes and verbal reports of the assistant or qualified personnel.*

In the case of a discharge anticipated within 3 treatment days of the Progress Report, the clinician may provide objective goals which, when met, will authorize the assistant or qualified personnel to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist, and services were provided or supervised by a clinician. The Discharge Note shall include all treatment provided

since the last Progress Report and indicate that the therapist reviewed the notes and agrees to the discharge.

At the discretion of the clinician, the discharge note may include additional information; for example, it may summarize the entire episode of treatment, or justify services that may have extended beyond those usually expected for the patient's condition. Clinicians should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed. The record should be reviewed and organized so that the required documentation is ready for presentation to the contractor if requested.

Assistant's Participation in the Progress Report

Physical Therapist Assistants or Occupational Therapy Assistants may write elements of the Progress Report dated between clinician reports. Reports written by assistants are not complete Progress Reports. The clinician must write a progress report during each Progress Report Period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the clinicians report. Progress Reports written by assistants supplement the reports of clinicians and shall include:

- 1. Date of the beginning and end of the reporting period that this report refers to;*
- 2. Date that the report was written (not required to be within the reporting period);*
- 3. Signature, and professional identification, or for dictated documentation, the identification of the qualified professional who wrote the report and the date on which it was dictated;*
- 4. Objective reports of the patient's subjective statements, if they are relevant. For example, "Patient reports pain after 20 repetitions". Or, "The patient was not feeling well on 11/05/06 and refused to complete the treatment session."; and*
- 5. Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively. For example: "increasing strength" is not an objective measurement, but "patient ambulates 15 feet with maximum assistance" is objective.*

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the Progress Report may be used to add, change or delete short term goals. Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name and date. Clinicians verify these changes by cosignatures on the report or in the clinician's Progress Report. (See section IV C) to modify the plan for changes in long term goals).

The evaluation and plan of care are considered incorporated into the Progress Report, and information in them is not required to be repeated in the report. For example, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current Progress Report Period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3.,) and the short term goals that relate to the long term goals may be

numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. A clinician, an assistant on the order of a therapist or qualified personnel on the order of a physician/NPP shall add new goals with new identifiers or letters. Omit reference to a goal after a clinician has reported it to be met, and that clinician's signature verifies the change.

Content of Clinician (Therapist, Physician/NPP) Progress Reports

In addition to the requirements above for notes written by assistants, the Progress Report of a clinician shall also include:

1. Assessment of improvement, extent of progress (or lack thereof) toward each goal;
2. Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report; and
3. Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.

A re-evaluation should not be required before every Progress Report routinely, but may be appropriate when assessment suggests changes not anticipated in the original plan of care.

Care must be taken to assure that they justify the necessity of the services provided during the reporting period, particularly when reports are written at the minimum frequency. Justification for treatment must include, for example, objective evidence or a clinically supportable statement of expectation that:

1. The patient's condition has the potential to improve or is improving in response to therapy;
2. Maximum improvement is yet to be attained; and
3. There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.

Example: The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink thick liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks. Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia. Short Term Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials. Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%. The Progress Report for 1/3/06 to 1/29/06 states: 1. Improved to 80% of trials; 2. Achieved. Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions. New Goal: "5. Patient will implement above strategies to swallow a sip of water without coughing for 5 consecutive trials. Mary Johns, CCC-SLP, 1/29/06." Note the provider is billing 92526 three times a week, consistent with the plan; progress is noted; skilled treatment is documented.

E. Treatment Note

The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes

on the claim. Documentation is required for every treatment day, and every therapy service. The format shall not be dictated by contractors and may vary depending on the practice of the responsible clinician and/or the clinical setting.

The Treatment Note is not required to document the medical necessity or appropriateness of the ongoing therapy services. Descriptions of skilled interventions should be included in the plan or the Progress Reports and are allowed, but not required daily. Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff may be reported voluntarily as additional information if they are relevant and not billed. Specifics such as number of repetitions of an exercise and other details included in the plan of care need not be repeated in the Treatment Notes unless they are changed from the plan.

Documentation of each Treatment shall include the following required elements:

1. Date of treatment; and
2. Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and
3. Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See CMS IOM, Pub. 100-04, chapter 5, section 20.2 or §XII for description of billing timed codes: and
- *4. Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment (i.e., the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law). The signature and identification of the supervisor need not be on each Treatment Note, unless the supervisor actively participated in the treatment. Since a clinician must be identified on the Plan of Care and the Progress Report, the name and professional identification of the supervisor responsible for the treatment is assumed to be the clinician who wrote the plan or report. When the treatment is supervised without active participation by the supervisor, the supervisor is not required to cosign the Treatment Note written by a qualified professional. When the responsible supervisor is absent, the presence of a similarly qualified supervisor on the clinic roster for that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation.

**If a treatment is added or changed under the direction of a clinician during the treatment days between the interval Progress Reports, the change must be recorded and justified on the medical record, either in the Treatment Note or the Progress Report, as determined by the policies of the provider/supplier. New exercises added or changes made to exercise program help justify that the services are skilled. For example: The original plan was for therapeutic activities, gait*

training and neuromuscular re-education. "On Feb. 1 clinician added electrical stim. to address shoulder pain."

Documentation of each Treatment may also include the following optional elements to be mentioned only if the qualified professional recording the note determines they are appropriate and relevant. If these are not recorded daily, any relevant information should be included in the progress report:

1. Patient self-report;
2. Adverse reaction to intervention;
3. Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.);
4. Significant, unusual or unexpected changes in clinical status;
5. Equipment provided; and/or
6. Any additional relevant information the qualified professional finds appropriate.

See CMS IOM Pub. 100-04, chapter 5, section 20.2 or § XII above for instructions on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes.

Denial Summary

The following situations will result in the denial of the initially billed PM&R services or in some cases as a result of a post-payment review.

Medical Necessity:

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section excludes coverage and payment for items and services that are not considered reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member.

1. Services determined to be performed solely for maintenance purposes will be denied as not medically necessary.
2. Claims submitted without an ICD-9 code to support medical necessity will be denied as not medically necessary.
3. It is not medically necessary for a supplier to perform or supervise maintenance programs that do not require the professional skills of a supplier.
4. Services provided by therapy aides under the supervision of therapist in independent practice are considered non-skilled services and will be denied as not medically necessary.
5. PM&R services performed by athletic trainer, massage therapist, recreation therapist, kinesiologist, low vision specialist or other like profession "incident to" a physician's/NPP's service are considered non-skilled services and will be denied as not medically necessary.
6. OT/PT evaluations/re-evaluation will be denied as not medically necessary when performed by OP/PT assistants.

Non-Covered:

Title XVIII of the Social Security Act section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

1. Physician's Services submitted without an ICD-9 code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.

2. PM&R services subject to the annual financial limitation, addressed in this policy, not reported with modifiers GN, GO, or GP will be denied as unprocessable.
3. Services exceeding the OT/PT Rehab. Financial Limit will be denied as non-covered.
4. PM&R services are not covered when the certification/recertification is not performed by the attending physician every 30 days.
5. Wound care involving the use of dressing, gauze, medication etc, but not involving active tissue removal would not meet the definition of CPT procedure code 97597, 97598, therefore would not be a covered service.
6. PM&R services performed or ordered/referred by chiropractors and doctors of dental medicine/surgery will be denied as not-covered. (Exception: Chiropractors participating in the Chiropractic Service Demonstration 04/01/2005-03/07/2007, IL only)
7. Chiropractic manipulations performed by physical therapists will be denied as non-covered.
8. PM&R services performed on a random basis, for the good and welfare of the patient do not meet the conditions for payment in 42CFR424.24c and SSA§1835(a)(2)(D) and will be denied as not covered.
9. PM&R services performed without the establishment of a treatment plan do not meet the conditions for payment in 42CFR424.24c and SSA§1835(a)(2)(D) and will be denied as not covered.

Source

CMS IOM BP Pub.100-2 Ch.15 §220-230.6 Rev.60.1, 63; CMS IOM CP Pub.100-4 Ch.5 §20.2 C

Notes

Italicized font – represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at <http://www.cms.hhs.gov/center/coverage.asp>

An asterisk (*) indicates a revision to that section of the policy.

This policy replaces Wisconsin policies PHYSMED-001, PHYSMED-008, and PHYSMED-010. Archived policies may be requested from Freedom of Information (FOI).

Dates/Revision History

Original Effective Date

03/01/2003

Date Published

*06/01/2008; 01/01/2008 (art), 02/01/2007 (art); 12/01/2006 (art); 04/01/2006 (article); 11/01/2005 (article); 10/01/2005 (article); 07/01/2005; 03/01/2004 (art); 12/01/2003 (art); 11/01/2003 (art); 03/01/2003

Effective Date/Number/Explanation

*06/01/2008, eleven, changed recertification to 90 days multiple per Pub 100-02 Rev 5921; 01/01/2008, Ten 2008 HCPCS code update added CPT code 96125, 01/01/2007 Nine (BP Rev 63); 12/09/2006 Eight (BP Rev.60.1, CP Rev.1019); 01/01/2006 Seven (BP Rev. 47); 07/25/2005 Six (Inc-to, code guide rev.); 7/25/2005 Five (BP-REV-36.1); 06/06/2005 Four (BP Rev.36, new format); 03/01/2004 Three (BP Rev. 5); 12/01/2003 Two (Rev. coding guideline #7.); 11/01/2003 One (Text rev. §II)