CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 60	Date: NOVEMBER 9, 2006
	Change Request 5271

This CR is being re-communicated to change the effective and implementation dates for non-systems changes to December 9, 2006 and for system changes the effective date is January 1, 2007 and the implementation date is January 2, 2007. All other material remains the same.

SUBJECT: Outpatient Therapy Cap Clarifications

I. SUMMARY OF CHANGES: Clarifies definitions and instructions related to Outpatient Therapy Services. Removing section 220.3.5 and renumbering to 220.3.

CLARIFICATION
EFFECTIVE DATE*: December 9, 2006, for non-systems changes, January 1, 2007, for systems changes
IMPLEMENTATION DATE: December 9, 2006, for non-systems changes, January 2, 2007, for systems changes

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
R	15/220/Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
R	15/220.1.2/Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
N	15/220.3/Documentation Requirements for Therapy Services

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal: 60	Date: November 9, 2006	Change Request 5271

This CR is being re-communicated to change the effective and implementation dates for non-systems changes to December 9, 2006 and for system changes the effective date is January 1, 2007 and the implementation date is January 2, 2007. All other material remains the same.

SUBJECT: Outpatient Therapy Cap Exceptions Clarifications

I. GENERAL INFORMATION

A. Background: Financial limitations on Medicare covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997 and were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005. The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to this dollar limitation may be made when provision of additional therapy services is determined to be medically necessary.

Cap amounts change annually and have recently been computed for 2007 and the amount of the caps has been added to this CR. Therefore, the language relative to the cap exceptions, which does not require systems changes, shall be effective and implemented 30 days after issuance. The language in this CR relative to the therapy cap update, and that which does require systems changes, shall be effective and implemented January 1, 2007, as required by statute and shall not be made public until November 1, 2006.

B. Policy: Section 1833(g)(5) of the Social Security Act provides that, for services provided during calendar year 2006, contractors shall, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, grant an exception to the therapy cap in certain circumstances. Claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Providers do not need to issue an ABN for these benefit category denials.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.1	The contractor shall grant exceptions for any number of medically necessary services that meet the outpatient therapy automatic process exception criteria, if the beneficiary meets the conditions described in IOM Pub. 100-04, chapter 5 for 2006.	X	X	X						A/B MAC
5271.2	The contractor shall utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance where a provider fails to submit all required documentation with the exception request in 2006.	X	X	X						A/B MAC
5271.3	The contractor shall grant an exception to the therapy cap, by way of approving any number of additional therapy treatment days, when those additional treatment days are deemed medically necessary based on documentation submitted by the provider in 2006.	X	X	X						A/B MAC
5271.4	The contractor shall grant an exception to the therapy cap, approving the number of treatment days requested by the provider/supplier/beneficiary, not to exceed 15 future treatment days, if the contractor does not make a decision within 10 business days of receipt of any request and appropriate documentation in 2006.	X	X	X						A/B MAC
5271.5	When reviewing claims for services excepted from therapy caps where there is evidence of potential provider fraud, the contractor shall follow the instructions in 100-08, chapter 4, on how to treat the claim in 2006.	X	X	X						A/B MAC
5271.6	When reviewing claims for services excepted from therapy caps the contractor shall deny the claim where there is evidence of misrepresentation of facts presented to the contractor by that provider in 2006.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.7	When reviewing claims for services excepted from therapy caps due to a pattern of aberrant billing the contractor shall deny the services that are not reasonable and necessary.	X	X	X						A/B MAC
5271.8	When replying to a request for exception, the contractor must reply as soon as practicable in 2006.	X	X	X						A/B MAC
5271.9	When replying to a request for exception, the contractor shall send the letter in Pub. 100-08, chapter 3 most appropriate to the circumstance in 2006.	X	X	X						A/B MAC
5271.10	The contractor shall develop a mechanism to track workload associated with the Therapy Cap process in 2006.	X	X	X						A/B MAC
5271.11	The contractor shall develop a mechanism to track costs associated with the Therapy Cap process in 2006.	X	X	X						A/B MAC
5271.12	For CY 2006, carriers and fiscal intermediaries shall report the therapy cap costs and workload on a monthly basis in activity code 27021 (not 21221). Note that if cap exceptions are extended beyond 2006, further instructions will be sent.	X	X	X						A/B MAC
5271.13	Contractors shall continue to report automatic and manual process exceptions separately on a monthly basis using the format and fields in the attachments to JSM/TDL-06427, 05-01-06 in 2006.	X	X	X						A/B MAC
5271.14	Contractors shall continue to enforce LCDs, since the presence of a KX does not supersede an LCD in 2006.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.15	Contractors shall note that the MSN messages in Pub. 100-04, chapter 21, have been modified to match the correct MSN messages in chapter 5.	X	X	X						A/B MAC
5271.15.1	Contractors shall modify MSN messages to match the MSN language in chapter 5, section 10.2D.	X	X	X						A/B MAC
5271.15.2	Modified MSN messages, as described in Pub. 100-04, chapter 5, section 10.2D shall be issued on all claims for outpatient therapy services until this instruction is changed.	X	X	X						A/B MAC
5271.16	Contractors shall note that the total amount paid for outpatient therapy services before the cap is reached, including deductible and coinsurance paid by the beneficiary, is $1740 for calendar year 2006.	X	X	X						A/B MAC
5271.17	Contractors shall note that the total amount paid for outpatient therapy services before the cap is reached, including deductible and coinsurance paid by the beneficiary, is $1780 for calendar year 2007.	X	X	X						A/B MAC
5271.17.1	CWF shall change the dollar amount for the limitation on outpatient physical therapy and speech-language pathology services combined to $1780 for dates of service from January 1, 2007 through December 31, 2007.	X	X	X		X			X	A/B MAC
5271.17.2	CWF shall change the dollar amount for the limitation on outpatient occupational services combined to $1780 for dates of service from January 1, 2007 through December 31, 2007.	X	X	X		X			X	A/B MAC
5271.18	Contractor shall, in <u>future</u> articles and publications that reference exceptions to therapy caps in 2006, refer to the automatic process and the manual process for exception as opposed to automatic exceptions and manual	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	exceptions.									
5271.19	Contractors shall follow the instructions in Pub. 100-04, chapter 5, for allowing outpatient therapy cap exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.	X	X	X						A/B MAC
5271.20	Contractors shall allow automatic process exceptions when complexities occur in combination with conditions that may or may not be on the list in Pub. 100-04, chapter 5, in 2006.	X	X	X						A/B MAC
5271.21	Contractors shall update the list of exceptions in 2006 according to the changes provided in this transmittal. Note that contractors may expand, but not remove ICD-9s from the list if their manual process exception decisions lead them to believe further exceptions should be allowed.	X	X	X						A/B MAC
5271.22	Contractors shall allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.	X	X	X						A/B MAC
5271.23	Contractors shall not utilize the KX modifier in data analysis as the sole indicator of services that DO exceed caps in 2006. For all claims, but especially for intermediary claims, there may be services with appropriately used KX modifiers that do not represent services that exceed the cap.	X	X	X						A/B MAC
5271.24	Contractors shall utilize consistently the new definitions and examples provided in this transmittal for Pub. 100-02, chapter 15.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.25	When a patient is being treated under the care of two physicians for separate conditions, contractors shall accept as appropriate documentation either a combined plan of care certified by one of the physicians/NPPs or two separate plans of care certified by separate physicians/NPPs.	X	X	X						A/B MAC
5271.26	Contractors shall not require the additional documentation that is encouraged but not required in Pub. 100-02, chapter 15.	X	X	X						A/B MAC
5271.26.1	In the event provider/suppliers fail to submit all requested documentation for the manual process therapy cap exception in 2006, contractors shall make determinations using clinical judgment based on all documentation received before the 10th day after submission of the request.	X	X	X						A/B MAC
5271.27	Contractors shall interpret a referral or an order or a plan of care dated after an evaluation as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.	X	X	X						A/B MAC
5271.28	Contractors shall not deny payment for re-evaluation only because an evaluation or re-evaluation was recently done. For example: 1) re-evaluation is covered and payable if documentation supports the need for re-evaluation; 2) re-evaluation may be appropriate prior to planned discharge for the purposes of a) determining whether goals have been met, or b) to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.29	Contractors shall, on pre or postpay medical review, require Progress Reports to be written by clinicians once during each Progress Report Period.	X	X	X						A/B MAC
5271.29.1	When required elements of the Progress Report are written into the Treatment Notes or in a Plan of Care, the contractors shall accept it as fulfilling the requirement for a Progress Report; a separate Progress Report shall not be required.	X	X	X						A/B MAC
5271.29.2	When therapists are not providing all of the treatment, contractors shall, if performing pre or postpay medical review, require a clinician's active participation in treatment at least during each Progress Report Period, except as noted in 5271.29.3.	X	X	X						A/B MAC
5271.29.3	When a clinician has not actively participated in treatment during the Progress Report Period due to the patient's unexpected absence, the contractor shall, if performing pre or postpay review, make a clinical judgment based on each individual case whether continued treatment after the Progress Reporting Period is medically necessary.	X	X	X						A/B MAC
5271.29.3.1	When a clinician has not actively participated in treatment during the Progress Report Period due to an unanticipated and unusual occurrence, the contractor shall, if performing pre or postpay review, make a clinical judgment based on each individual case whether continued treatment after the Progress Reporting Period is medically necessary.	X	X	X						A/B MAC
5271.29.3.2	When a clinician has not actively participated in treatment during the Progress Report Period, the contractor shall, if performing prepay or postpay medical review, include in their consideration of medical necessity whether documentation indicates the clinicians active guidance of treatment during the reporting	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	period.									
5271.29.3.3	When a clinician has not actively participated in treatment during the reporting period, the contractor shall, if performing prepay or postpay medical review, include in their consideration of medical necessity whether documentation indicates that continued services beyond the reporting period are likely to be as safe and appropriate for the beneficiary as the alternative of discontinuing treatment	X	X	X						A/B MAC
5271.30	Contractors shall require, if performing pre or postpay medical review of documentation, that when the services incident to a physician's services 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.	X	X	X						A/B MAC
5271.31	CWF shall exclude from the financial limitation on outpatient therapy described in Pub. 100-04, chapter 5, section 10.2 claims having the all the following conditions: 1. Dates of services from January 1, 2006 through December 31, 2007; 2. Modifier of GN, GO, or GP; and 3. Place of service code equals 22 (outpatient hospital) or 23 (emergency room-hospital).								X	
5271.32	CWF shall apply the outpatient therapy financial limitation described in Pub. 100-04, chapter 5, section 10.2 in the order of date received.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.33	Contractors shall deny claims for outpatient therapy services exceeding the financial limits described in Pub. 100-04, chapter 5 section 10.2 as indicated by CWF and as appropriate according to Medicare policy.	X	X	X						A/B MAC
5271.34	Contractors shall modify Medicare Summary Notices (MSNs) 17.13, 17.18, and 17.19 such that when the calendar year is 2007, the ($) limit is $1780 effective January 1, 2007.	X	X	X						A/B MAC
5271.35	Contractors shall change any reference in their educational materials to reflect therapy limits for CY 2007 as $1780 for physical therapy and speech-language pathology combined and $1780 for occupational therapy.	X	X	X						A/B MAC
5271.36	The CWF shall display the therapy cap amount applied per beneficiary on all CWF inquiry screens (HIMR, HIQA, HUQA, HIQH, ELGA, ELGB, and ELGH)								X	
5271.37	In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount to CWF as the amount applied to therapy limits.					X	X			

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5271.38	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive	X	X	X						A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: **December 9, 2006, for non-systems changes, January 1, 2007 for systems changes**	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating**

Implementation Date: December 9, 2006, for non-systems changes, January 2, 2007 for systems changes **Pre-Implementation Contact(s):** Exceptions Process and Medical Review: Dan Schwartz (daniel.schwartz@cms.hhs.gov) or Kim Spalding (kimberly.spalding@cms.hhs.gov); Clinical and Documentation Issues: Dr. Dorothy Shannon (dorothy.shannon@cms.hhs.gov); Claims Processing: Claudette Sikora (claudette.sikora@cms.hhs.gov) or Wil Gehne (Wilfred.gehne@cms.hhs.gov) Appeals: David Danek (david.danek@cms.hhs.gov) **Post-Implementation Contact(s):** Regional offices	**budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Benefit Policy Manual
Chapter 15 – Covered Medical and Other Health Services

Table of Contents
(Rev. 60, 11-08-06)

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

(Rev. 60, Issued: 11-09-06; Effective: 12-09-06; Implementation: 12-09-06)

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 www.cms.hhs.gov/mcd.

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/.

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A. Definitions

The following defines terms used in this section and §230:

ACTIVE PARTICIPATION of the clinician in treatment means that the clinician personally furnishes in its entirety at least one billable service on at least one 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 i*s distinguished from *language in* Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment*,* which may be payable). Assessment*s 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 judgment*s* 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/nonphysician 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 1 month, whichever is longer.*

The 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.

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 the 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*.

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 re-evaluation at specific intervals, for Medicare payment, re-evaluations must meet Medicare coverage guidelines. The decision to provide a *re-*evaluation shall be made by a clinician.

INTERVAL of treatment consists of 1 month or 30 calendar days *whichever is more.*

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 sections 220 and 230 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 section 230.1 and 230.2) 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 §230.5 of this manual. 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 (e.g., hand written, electronic, or signature stamp). Policies in CMS IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.4.1.1 (B) concerning signatures apply.

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 §230.3.)

THERAPIST refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, 230.2, and 230.3.

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 *when provided in hospitals that are exempt from the hospital* Outpatient Pros*pective Payment System and paid on a reasonable cost basis, including Critical Access Hospitals.*

Therapy services referred to in this manual are those skilled rehabilitative services provided according to the standards and conditions in CMS manuals, (e.g., in this chapter and in the Medicare Claims Processing Manual, CMS IOM Pub. 100-04, 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 CMS IOM 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).

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 in a day, plans of care indicate treatment amount of twice a day.

B References

Paper Manuals. The following manuals, now outdated, were resources for the Internet Only Manuals.

- Part A Medicare Intermediary Manual, (Pub. 13)
- Part B Medicare Carrier Manual, (Pub. 14)
- Hospital Manual, (Pub. 10)
- Outpatient Physical Therapy/CORF Manual, (Pub. 9)

Regulation and Statute. The information in this section is based in part on the following current references:

- 42CFR refers to Title 42, Code of Federal Regulation (CFR).
- The Act refers to the Social Security Act.

Internet Only Manuals. Current Policies that concern providers and suppliers of therapy services are located in many places throughout CMS Manuals. Sites that may be of interest include:

- Pub.100-01 GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT,
  - Chapter 1- General Overview

    10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice and SNF Services - A Brief Description
    10.2 - Posthospital Home Health Services
    10.3 - Supplementary Medical Insurance (Part B) - A Brief Description
    20.2 - Discrimination Prohibited
- Pub. 100-02, MEDICARE BENEFIT POLICY MANUAL
  - Ch 6 - Hospital Services Covered Under Part B

    10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals
    20 - Outpatient Hospital Services
    20.2 - Distinguishing Outpatient Hospital Services Provided Outside the Hospital
    20.4.1 - Coverage of Outpatient Therapeutic Services
    70 - Outpatient Hospital Psychiatric Services
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      230.8 - Non-implantable Pelvic Flood Electrical Stimulator
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290.1 - Home Health Visits to A Blind Diabetic

- Pub. 100-08 PROGRAM INTEGRITY MANUAL
  - Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

  - Chapter 13 - Local Coverage Determinations

13.5.1 - Reasonable and Necessary Provisions in LCDs

Specific Therapy Policies**.** Sections 220 and 230 of this chapter describe the standards and conditions that apply generally to outpatient rehabilitation therapy services. Specific policies may differ by setting. Other policies concerning therapy services are found in other manuals. When a therapy service policy is specific to a setting, it takes precedence over these general outpatient policies. For special rules on:

- CORFs - See chapter 12 of this manual and also Pub. 100-04, chapter 5;
- SNF - See chapter 8 of this manual and also Pub. 100-04, chapter 6, for SNF claims/billing;
- HHA - See chapter 7 of this manual, and Pub. 100-04, chapter 10;
- GROUP THERAPY AND STUDENTS - See Pub.100-04, chapter 5, §100.10;
- ARRANGEMENTS - Pub. 100-01, chapter 5, §10.3;
- COVERAGE is described in the Medicare Program Integrity Manual, Pub. 100-08, chapter 13, §13.5.1; and
- THERAPY CAPS - See Pub. 100-04, chapter 5, §10.2, for a complete description of this financial limitation.

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.

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

(Rev. 60, Issued: 11-09-06; Effective: 12-09-06; Implementation: 12-09-06)

Reference: 42CFR 410.61

A. Establishing the plan (See §220.1.3 for certifying 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 §§220.1.1 and 220.1.3

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

- 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);
- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or
- 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. Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same *clinician* who establishes the plan. Payment for services provided before a plan is established may be denied.

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 (See §220.1.3 for certifying the plan.)
The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24 and 410.61) *(See §220.3 for further documentation requirements)*:

- Diagnoses;
- Long term treatment goals; and
- 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.

Long term treatment goals should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care.

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 specify the type (PT, OT, SLP) of therapy planned.

There shall be different plans of care for each type of therapy discipline. When 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 are 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.

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.

C. Changes to the Therapy Plan

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

- The physician/NPP;
- The physical therapist (in the case of physical therapy);
- The speech-language pathologist (in the case of speech-language pathology services);
- The occupational therapist (in the case of occupational therapy services; or
- 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. An insignificant alteration in the plan would be a decrease 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. 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).

220.3 - Documentation Requirements for Therapy Services

(Rev. 60, Issued: 11-09-06; Effective: 12-09-06; Implementation: 12-09-06)

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 sections 220 and 230 of this chapter* 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.

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

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*:

- 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;

- 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 of the plan is required for payment made after the certification interval.*

- Progress Reports when *records are requested after the reports are due.* (*See definitions in section 220 and descriptions in 220.3 D)*);

- Treatment Notes *for each treatment day* (may also serve as Progress Reports when required information is included in the notes); and

- For therapy cap exceptions, records justifying services over the cap. 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 use of the KX modifier.

Contractors shall not require more specific documentation unless other Medicare 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.

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. The date the documentation *was made* is *important* only to *establish the date of the initial* the 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 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 one week after the end of the month described in the report.*

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:

- The patient is under the care of a physician/NPP;
    - Physician/NPP care shall be documented by physician/*NPP* certification (approval) of the plan of care; and
    - *Although not required, o*ther evidence of physician/*NPP* involvement in the patient's care may include, for example: order/referral, conference, team meeting notes,
- Services require the skills of a therapist.
    - 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 the 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.

- 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.

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 or re-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 or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others.*

Evaluation shall include:

- 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;

- Objective measurements, preferably standardized patient assessment instruments and/or outcomes measurement tools related to current functional status, when these are available and appropriate to the condition being evaluated;

- 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

- 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.

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 section 220. Re-evaluations are usually focused on the current treatment and m*ight* 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, or for the use of the physician or the treatment setting 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 section 220.1.2 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 *R*eport provides justification for the medical necessity of treatment. *Contractors shall determine the necessity of services based on the delivery of services as directed 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 and 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 certification* interval, whichever is less. *The beginning of 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 last day of the certification interval, 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.

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 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 seven calendar days 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 R*eports may be written in the *Treatment N*otes 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. 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.*

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 this chapter. 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 *T*reatment *N*ote 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 *D*ischarge *N*ote *is required for each episode of treatment. 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 three 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:

- Date of the beginning *and end* of the *reporting period* that this report refers to;
- Date that the report was written *(not required to be within the reporting period*);

- 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;

- 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

- 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 R*eport 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 220.1.2(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, i*f 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 a*dd 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 R*eport of a clinician shall also include:

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;

- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report; and

- 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 documentation justifies 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:

- *The patient's condition has the potential to improve or is improving in response to therapy;*

- *Maximum improvement is yet to be attained; and*

- *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 *documented*; 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 *N*otes 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:

- Date of treatment; *and*

- 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*

- 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. *T*he billing and the total timed code treatment minutes must be consistent. See CMS IOM, Pub. 100-04, chapter 5, section 20.*2* for description of billing timed codes*; and*

- 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 the *help* of 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, but the supervisor's identification must be clear in the Plan of Care, or Progress 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 a supervisor is absent, the presence of a similarly qualified supervisor on that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation. Since a clinician must sign the Progress Report, the name and professional identification of the supervisor shall be included in the Progress Report.

If a treatment is added or changed under the direction of a clinician during the treatment days between the interval *P*rogress *R*eports, 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

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

See CMS IOM Pub. 100-04, chapter 5, section 20.2 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.