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Revisions to the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15, Sections 220 and 230 Regarding Therapy Services

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Physicians and other providers who bill Fiscal Intermediaries (FIs) and carriers for therapy services

Provider Action Needed



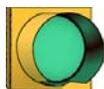
STOP – Impact to You

This manual revision re-organizes sections 220 and 230 in Chapter 15 of the Medicare Benefit Policy Manual; it adds reference information and clarifies current policy concerning physician visits and certification. In addition, it defines the qualifications of therapists.



CAUTION – What You Need to Know

Please note that to ensure payments for therapy services you must meet the conditions and standards for therapy services described in the manuals. In addition, the qualified therapy service must be furnished by qualified professionals/personnel as defined in the Medicare Benefit Policy Manual.



GO – What You Need to Do

To ensure accurate and timely processing of therapy claims, be familiar with instructions and requirements described in the Centers for Medicare & Medicaid Services (CMS) Manual System related to such claims. Read the detailed policies in the manuals and contact your intermediary or carrier if you have any questions about these changes.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Background

In summary, this revision to the *Medicare Benefit Policy Manual* (Pub 100-02), Chapter 15, Sections 220 and 230, does the following:

- Clarifies policies concerning orders, visits, plans of care, delayed certification, and private practice; and
- Incorporates the information in the Final Rule of November 15, 2004 concerning the definition of therapy services, the qualifications of therapists, therapy services provided incident to a physician, and supervision in private practice settings.

Some key points in this modification include:

- Medicare carriers and FIs will pay for services only when the services meet the conditions and standards described in the Medicare Benefit Policy Manual. This includes requirements regarding the qualifications of the person who provides the service as detailed in that manual.
- Medicare carriers/FIs will not deny therapy claims based only on the absence of an order or referral for therapy services. However, claims will be denied if there is no certification of the plan of care for each 30 day interval of treatment. The certification indicates the patient was under the care of a physician, and needed the treatment that was approved by the physician or nonphysician practitioner who certified the plan.
- On prepay or postpay review, if the carrier/FI finds there is no documentation indicating a physician or non-physician practitioner certification of a therapy plan of care for treatment for the first 30 days of treatment or finds there is no certified plan of care for treatment for each interval of 30 days from the last certified interval of treatment, the claim will be denied, unless there is a delayed certification.
- On review, the carrier/FI will count the days from the first date treated by the therapist to determine if the certification of the plan is delayed.
- Medicare carriers/FIs will accept delayed certification of services that would otherwise be covered unless the claim, the justification, or any accompanying documentation indicates the treatment was not clinically necessary, i.e., the service does not meet the patient's need.
- Medicare does not require a physician visit prior to certification, but the physician or nonphysician practitioner who certifies the plan may require a visit prior to certification.

Additional Information

This manual change does not require a change in the way therapy services are currently provided. You may continue to obtain an order, send the plan of care promptly to the physician, obtain certification as soon as you can and recommend a visit to the physician when needed.

However, in the case where a physician does not promptly return a certification of the plan of care for a patient under his/her care, this change provides some flexibility in obtaining the certification.

Also, a physician retains the authority to require that a patient under his/her care must return for a visit prior to certification, and the physician may limit the length of time for which the plan is certified, or may chose to certify an interval in advance if it is medically appropriate.

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The revised sections of the *Medicare Benefit Policy Manual* are attached to the official instruction issued to your carrier/FI regarding this change. That instruction, CR3648, can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf> on the CMS website.

If you have questions regarding this issue, you may also contact your carrier or FI at their toll free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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