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Therapy Personnel Qualifications and Policies Effective January 1, 2008

Note: This article was updated on July 12, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, non physician practitioners, and other providers who bill Medicare carriers, fiscal intermediaries (FI) or Medicare Administrative Contractors (A/B MAC) for outpatient therapy services provided to Medicare Beneficiaries.

What Providers Need to Know

CR 5921, from which this article is taken, provides guidance for new regulations (See the Federal Register of November 27, 2007 for the discussion in the Medicare Physician Fee Schedule (MPFS) final rule of 2008.) that address outpatient therapy services, including personnel qualifications and the timing of recertification of plans of care for Part B services. This article summarizes these regulations.

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Background

Professional standards have changed since the qualifications for individuals providing outpatient therapy services (physical therapy, occupational therapy and speech-language pathology services in 42CFR484.4 was last modified. In the calendar year 2008 Medicare Physician Fee Schedule Final Rule with comments, the Centers for Medicare & Medicaid Services (CMS) updated them to address more modern requirements. CR 5921, from which this article is taken, provides guidance for these new regulations.

Effective January 1, 2008, these personnel requirements are being applied to all settings except inpatient hospital, including critical access hospital services, and posthospital SNF care.

Effective July 1, 2008, these personnel qualifications are being applied consistently in all Medicare settings where therapy services are furnished.

Certain other policies concerning therapy services, and policies concerning recertification of plans of care for Part B services, some of which differ by setting are also effective January 1, 2008.

Note: The regulations in 42CFR409.17 concerning inpatient hospital services and inpatient critical access hospital services, and those in 42CFR409.23 concerning post hospital skill nursing facility (SNF) care will become effective July 1, 2008. Only the personnel qualifications for those settings are addressed in this CR.

Qualifications for Individuals Providing Outpatient Therapy Services

Practice of Physical Therapy

For Medicare program coverage purposes, the new personnel qualifications for physical therapists were discussed in the 2008 Medicare 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. To view the official qualifications for physical therapists, see the revised Chapter 15, Section 230.1, of the Medicare Benefit Policy Manual, which is attached to CR5921 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R88BP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

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Practice of Occupational Therapy

The new personnel qualifications for occupational therapists (OT) were also 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 official personnel qualifications of OTs are in the revised Chapter 15, Section 230.2 of the Medicare Benefit Policy Manual attached to CR5921.**

Practice of Speech-Language Pathology

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.

Timing of Recertification of Plans for Care for Part B services

CR 5921 also addresses the timing of recertification of plans for care for Part B services. The following summarizes the changes articulated in the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care).

First, please note that the physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements for the duration of the episode 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.

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The timing of plan recertification changed on January 1, 2008. Therefore, those certifications that were signed on, or prior to December 31, 2007, follow the rule in effect at that time; which required recertification every 30 calendar days. However, certifications that are signed on, or after January 1, 2008, follow the new rules in CR5921 and are effective for an appropriate episode length based on individual patient condition up to 90 calendar days from the initial therapy treatment.

Specifically, a physician/NPP may certify or recertify a plan for whatever duration of treatment episode they determine is appropriate, up to a maximum of 90 calendar days. A certification interval will be the same length as an episode, if the episode is less than 90 calendar days. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification, it is appropriate (although not required) that the clinician who develops the plan estimate the duration of the entire episode for that setting.

Note: The Progress Report Period has not changed. Progress reports are due at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The first day of the first reporting period is the same as the first day of the certification period and the first day of treatment (including evaluation). The first day of the second reporting period is the treatment day after the end of the first reporting period.

Other Issues in CR5921

Other issues discussed in CR5921 include:

- Medicare contractors will require that a new or significantly modified (changed) plan of care for outpatient therapy services be certified no more than 30 calendar days after the initial therapy treatment under that plan. Rules for delayed certification have not changed.
- Payment and coverage conditions require that the plan must be reviewed, as often as necessary but at least whenever it is certified or recertified. It is not required that the same physician/NPP who participated initially in recommending or planning the patient's care certifies and/or recertifies the plans.
- Medicare contractors will require recertification of outpatient therapy plans of care in intervals not to exceed 90 calendar days after the initial treatment day.
- Physicians/NPPs who feel that a visit for an examination is necessary prior to certifying the plan, or during the episode of treatment should

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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.

- Policies continue to allow delayed certification of plans of care. Certifications are acceptable, even when late, if the services appear to have been provided under the care of any physician (not only the one who certifies). Appearance of a physician's care may be in any form and includes orders, e.g., notes, phone conferences, team conferences and billing for physician 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.
- The guidance for delayed certification has not changed. A new plan of care is either an initial plan of care or a plan of care that has been significantly modified or changed, resulting in a change in long term goals. It is expected that modifications to the plan concerning short term goals or treatment techniques will be made frequently and these changes do not require certification or recertification.
- Medicare contractors will not require a certification "statement" at the time of certification.
- Medicare contractors will require a clinicians or facilities that appropriately furnish aquatic therapy in a community pool to rent or lease at least a portion of the community pool for the exclusive use of the therapist's patients.
- The same policies, e.g., concerning safety and medical necessity, continue to apply to services provided in part of a pool as were applied when the policy required use of the entire pool.

Additional Information

You can find more information about the new therapy personnel qualification requirements and the timing of recertification of plans of care (effective January 1, 2008) by going to CR 5921, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R88BP.pdf> on the CMS website.

The updated Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), Sections 220 (Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-

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Language Pathology Services) Under Medical Insurance), 220.1.2 (Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services), 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care), 220.3 (Documentation Requirements for Therapy Services), 230.1 (Practice of Physical Therapy), 230.2 (Practice of Occupational Therapy), 230.3 (Practice of Speech-Language Pathology), 230.4 (Services Furnished by a Physical or Occupational Therapist in Private Practice) can be found as an attachment to that CR.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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