OUTPATIENT REHABILITATION THERAPY SERVICES: COMPLYING WITH DOCUMENTATION REQUIREMENTS

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This booklet describes common outpatient rehabilitation therapy services Comprehensive Error Rate Testing (CERT) Program errors, how the Centers for Medicare & Medicaid Services (CMS) calculates improper payment rates, the necessary documentation to support billed Medicare claims, and managing potential overpayments. Outpatient rehabilitation therapy services include physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services.

Learn about:

- CERT Program
- Billing for Medicare Part B outpatient PT, OT, and SLP services
- Reducing common errors and overpayments for PT, OT, and SLP services

CMS works to eliminate improper payments in the Medicare Program and protect the Medicare Trust Fund, as well as beneficiaries from medically unnecessary services or supplies and their associated costs. CMS calculates a national Medicare Fee-For-Service (FFS) improper payment rate and improper payment rates by claim type and publishes the review results annually. This report allows CMS to determine the most common incorrectly billed or documented coverage areas and create targeted educational materials to address them.

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When a provider submits an outpatient therapy Part B claim, if the Medicare Administrative Contractor (MAC) identifies a potential overpayment within 6 years of the date a provider receives it (generally referred to as the "look back period"), the provider must investigate and return all identified overpayments. Refer to the Social Security Act (SSA) § 1128J(d) for more information.

Medicare covers outpatient PT, OT, and SLP services only when providers meet medical necessity, documentation, and coding requirements.

Background

Medicare covers outpatient PT, OT, and SLP services when:

- A physician or non-physician practitioner (NPP) clinically certifies the treatment plan/plan of care (POC), ensuring:
  - The patient needs the therapy services
  - A treatment plan/POC is:
    - Established by a physician/NPP, or a qualified therapist providing such services
    - Reviewed periodically by a physician/NPP
  - The patient is under physician care while getting services
- Claims include the POC's certifying provider's National Provider Identifier (NPI)
- Claims include functional reporting (beginning January 1, 2019, this requirement no longer applies)
- Claims include the patient's functional limitations consistent with the identified treatment plan/POC functional limitations (applies to claims for CY 2013 through CY 2018)

NOTE: Beginning for claims with dates of service on and after January 1, 2019, reporting requirements for functional limitations HCPCS G-codes and severity modifiers no longer apply.

Physician/NPP and Qualified Therapist Defined

A **physician** is a Doctor of Medicine, osteopathy, podiatric medicine, or optometry (only for low vision rehabilitation).

An **NPP** is a physician assistant (PA), clinical nurse specialist (CNS) or nurse practitioner (NP).

A **qualified therapist** includes a PT, OT, or SLP who meets regulatory qualifications (at 42 CFR 484) as applicable, including licensure or certification by the state. Go to the Medicare Benefit Policy Manual Chapter 15, Sections 230.1 – 230.3, Practice of PT, OT, and SLP for more information.

Common CERT Errors

Table 1 has information about common top outpatient rehabilitation therapy services, improper payments and payment rates errors, and prevention methods.

Table 1. Common Outpatient Rehabilitation Therapy CERT Errors

Error	Prevention
Missing certification and recertification(s) – the physician/NPP's dated signature(s) approving the POC	Confirm the physician/NPP certified the POC (and recertified it when appropriate) with their signature and date.
Missing physician/NPP, therapist signature who developed the POC, and the established treatment plan date	Make sure to include your signature, professional identification (for example, PT, OTR/L), and the POC established date.
Missing or incomplete POC	Create a complete POC that includes: Diagnoses, long-term goals, type, amount, frequency, and services duration.
Missing significant POC changes certifications and recertification(s)	Ensure a significantly modified POC is certified, (physician/NPP signs and dates it).
Missing the required functional reporting on claims and/or medical record	Each reporting period must include G-codes and severity modifiers documented in the medical record on the same date reported on claims. Your MAC cannot process your claim without them. **NOTE:** CMS discontinued reporting functional information on claims for services dated on or after January 1, 2019.
Missing total time for the timed procedures and total active treatment time	Clearly document in minutes, the total treatment time for the 15-minute timed codes to support the number of units and codes billed for each treatment day. Also, document the total active treatment time (including timed and untimed codes) in the patient's medical record.
Missing or incomplete initial evaluation	Document the initial evaluation, include your signature, professional identification (for example, PT, OTR/L), and date you performed the initial evaluation. Refer to documentation requirements of evaluations and re-evaluations in the Medicare Benefit Policy Manual, Chapter 15, Section 220.3 for more information.

Table 1. Common Outpatient Rehabilitation Therapy CERT Errors (cont.)

Error	Prevention
Missing or incomplete progress reports	Progress reports must include certain information, be done with frequency (at least once each 10 treatment days), and contain your signature, professional identification, and date. The CERT program does not include progress reports. Refer to documentation requirements of progress reports in the Medicare Benefit Policy Manual, Chapter 15, Section 220.3 for more information.
Missing elements to support medical necessity	The documentation needed to support the medical necessity of PT, OT, and SLP services is outlined throughout Sections 220 and 230 of the Medicare Benefit Policy Manual, Chapter 15, including Section 220.2 for Reasonable and Necessary Outpatient Rehabilitation Therapy Services.

CERT Outpatient Rehabilitation Therapy Services Documentation

Written POC

Outpatient rehabilitation therapy services must relate directly and specifically to a written treatment plan (also known as the POC). You must establish the treatment plan/POC before treatment begins, with some exceptions. CMS considers the treatment plan/POC established when it is developed (written or dictated) by a PT, an OT, an SLP, a physician, or an NPP. Only a physician may establish a POC in a Comprehensive Outpatient Rehabilitation Facility (CORF).

At a minimum, the POC must contain:

- Diagnoses
- Long-term treatment goals
- Type of rehabilitation therapy services (PT, OT, or SLP) – where appropriate; the type may be a description of a specific treatment or intervention
- Therapy amount – number of treatment sessions in a day
- Therapy frequency – number of treatment sessions in a week
- Therapy duration – total number of weeks or number of treatment sessions

Record the signature and professional identity of the person who established the POC and the date they established it. The physician/NPP must approve – via their documented written or verbal approval − when a significant change is made to the already certified POC. A change in a long-term goal (for example, if a new condition were to be treated) represents a significant change. The POC should provide the most effective and efficient treatment balanced with appropriate resources and the best outcome.

Initial Certification of the Plan of Care

The physician's/NPP's signature and date on a correctly written POC (with or without an order) satisfies the certification requirement for the duration of the POC or 90 calendar days from the date of the initial treatment, whichever is less. Include the initial evaluation indicating the treatment need in the POC.

The physician/NPP certifies the initial POC with a dated signature or verbal order within 30 days following the first day of treatment (including evaluation). The physician/NPP must sign and date verbal orders within 14 days.

Recertification

Sign the recertification, documenting the need for continued or modified therapy whenever a significant POC modification becomes evident or at least every 90 days after the treatment starts. Complete recertification sooner when the duration of the plan is less than 90 days, unless a certification delay occurs. CMS allows delayed certification when the physician/NPP completes certification and includes a delay reason. CMS accepts certifications without justification up to 30 days after the due date. Recertification is timely when dated during the duration of the initial POC or within 90 calendar days of the initial treatment under that plan, whichever is less.

Billing Procedure Units

When reporting service units for untimed HCPCS codes (the procedure is undefined by a specific time frame), report "1" in the unit field (for example, HCPCS codes for therapy evaluations, group therapy, and supervised modalities). You must report other untimed codes (for example, "add-on" codes) based on the number of times the health care professional performed the procedure (for example, bill an add-on HCPCS debridement code, in addition to its "base" code, for each additional 20 square centimeters of tissue removed).

Some HCPCS codes are defined by direct (one-on-one) time spent in patient contact for each 15 minutes. The number of units for these timed codes reported per discipline for each date, regardless of the number of different treatments furnished, is determined by the total treatment time for the timed codes.

Document the total minutes under timed codes in the medical record for each date of service to support the number of units and codes billed. Also, report the total active treatment services minutes, including timed and untimed procedures/modalities.

Therapy Modifier Requirements

All claims for outpatient therapy service must report a therapy modifier (GP, GO, GN) along with the HCPCS code to indicate the treatment plan discipline (PT, OT, SLP). Also, certain HCPCS codes require certain therapy modifiers. Refer to MM10176 and MM9698 for more information.

Correctly Using Timed and Untimed Codes

CMS requires that when you provide only one 15-minute timed HCPCS code in a day, that you do not bill that service if performed for less than 8 minutes. When providing more than one unit of service, the initial and subsequent service must each total at least 15 minutes, and the last unit may count as a full unit of service if it includes at least 8 minutes of additional services. Do not count all treatment minutes in a day to one HCPCS code if more than 15 minutes of one or more other codes are furnished.

If a therapist furnishes four distinct, separate 8-minute treatments (32 treatment minutes total), do not report four 15-minute treatment units on the claim. In this circumstance, you may report only two units (at least 23 minutes but less than 38 minutes). You may report a third unit when you furnish a total of 38 through 52 minutes; and, a fourth unit may be billed if you deliver at least 53 but less than 68 minutes of treatment. Do not report units on the claim that exceed the total treatment minutes for the timed codes.

If you report both timed and untimed codes on the same claim, do not count time spent on untimed-code services toward the timed-code services.

Go to the Medicare Claims Processing Manual, Chapter 5, Section 20.2 for more information about HCPCS Coding Requirement, including examples of correctly using 15-minute codes when providing one or multiple therapy services, including procedures and/or modalities, in a day.

Functional Reporting

For dates of service January 1, 2013, through December 31, 2018, CMS used functional reporting to collect data on patient function during the therapy episode of care to better understand patient functional limitations and outcomes. During those years, certain claims for outpatient rehabilitation therapy services were required to include HCPCS G-codes representing the primary functional limitation and severity modifiers to report a patient's functional status. These G-codes and modifiers also had to be documented in the patient's medical record on each date of service functional reporting was required. Go to the MLN Matters® articles, Outpatient Therapy Functional Reporting Requirements and Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018 or visit the CMS Functional Reporting webpage for more information.

Resources

Table 2. Resource Table

Resources	Website
Medicare Benefit Policy Manual, Chapter 12	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c12.pdf • Section 20 – Required and Optional CORF Services • Section 30.E – Plan of Treatment
Medicare Benefit Policy Manual, Chapter 15	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf • Section 220 – Definitions Related to Therapy Services • Section 220.1.2 – Plan of Care/Treatment Plan • Section 220.1.3 – Certification/Recertification • Section 220.2 – Reasonable and Necessary • Section 220.3 – Documentation Requirements • Section 220.4 – Functional Reporting • Section 230 A-B – Group Therapy and Students • Sections 230.1 – 230.3 Practice of PT, OT, and SLP • Section 230.4 − Services Furnished by a Therapist in Private Practice (TPP) • Section 230.5 − PT, OT and Pathology Services Provided Incident to the Services of Physicians and NPP
Documentation to Support the Reasonableness and Medical Necessity of Therapy Services	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf • Sections 220 and 230 (including 220.2 for Reasonable and Necessary Outpatient Rehabilitation Therapy Services)
Medicare Claims Processing Manual, Chapter 5	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf • Sections 10.2 – 10.5 – Therapy Limitations • Section 10.6 – Functional Reporting • Section 20 – HCPCS Coding Requirements • Section 20.2 – Reporting of Service Units with HCPCS that includes subsection titled “Counting Minutes for Timed Codes in 15 Minute Units”

Table 2. Resource Table (cont.)

Resources	Website
Medicare General Information, Eligibility and Entitlement Manual, Chapter 5	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c05.pdf • Section 10.3 – “Under Arrangements” Defined
Medicare Program Integrity Manual Chapter 3	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf • Section 3.3.2.4 – Signature Requirements
Medicare Program Integrity Manual Chapter 13	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf • Local Coverage Determinations
Use the State Index Tool to Locate Local Coverage Determinations In Your State	CMS.gov/medicare-coverage-database/indexes/lcd-state-index.aspx • Local Coverage Determinations by State Index

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
Calculates Improper Payment Rates	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Background.html
Comprehensive Error Rate Testing (CERT) Program	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT
Functional Reporting	https://www.cms.gov/Medicare/Billing/TherapyServices/Functional-Reporting.html
Medicare Benefit Policy Manual, Chapter 15	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Medicare Claims Processing Manual, Chapter 5	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf
MM101706	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10176.pdf

Table 3. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
MM9698	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9698.pdf
Outpatient Therapy Functional Reporting Requirements	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1307.pdf
Social Security Act (SSA) § 1128J(d)	https://www.ssa.gov/OP_Home/ssact/title11/1128J.htm
Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11120.pdf

Disclaimer:

The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Contractor Task Force is independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

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