

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 63	Date: December 29, 2006
	Change Request 5478

SUBJECT: Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007

I. SUMMARY OF CHANGES: Changes to augment descriptions of medically necessary services that qualify for exceptions to therapy caps. Clarifications of some definitions and the description of group and student services are moved from Pub 100-04 to 100-02.

New / Revised Material

Effective Date: January 1, 2007

Implementation Date: On or before January 29, 2007.

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	15/220 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
R	15/220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services
R	15/220.3 - Documentation Requirements for Therapy Services
R	15/230 - Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology

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: 63	Date: December 29, 2006	Change Request: 5478
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SUBJECT: Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007

Effective Date: January 1, 2007

Implementation Date: On or before January 29, 2007.

I. GENERAL INFORMATION

A. Background: Financial limitations on Medicare covered therapy services (therapy caps) were implemented on January 1, 2006. In the Deficit Reduction Act, Congress provided that exceptions to this dollar limitation may be made when provision of additional therapy services is determined to be medically necessary. This exceptions process was initially effective only for services provided in CY2006. Recent legislation, the Tax Relief and Health Care Act of 2006, has extended the application of this exceptions process for 1 year, CY2007.

This Change Request provides instructions to contractors regarding the short term implementation of this legislation. During calendar year 2006, local contractor controlled processes implemented the exceptions to the therapy cap. A nationally consistent systematic process to implement the exceptions is preferable to local processes. In order to meet legislated timeframes, local processes will be continued in the short term. These processes will be replaced by national system changes as soon as is practicable. The national process will be described in a subsequent instruction.

B. Policy: Section 1833(g)(5) of the Social Security Act, as amended by the Tax Relief and Health Care Act of 2006, provides that, for services provided during CY2007 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 Advance Beneficiary Notice for these benefit category denials.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A / B M A C	D M E M A C	F I	C A R R I E R	D M R C	R H I	Shared-System Maintainers				OTHER	
						F I S S	M C S	V M S	CWF				
5478.1	Contractors shall apply exceptions in this CR to the therapy financial limitations to services provided to Medicare eligible beneficiaries in CY2007.	X		X	X		X						
5478.1.1	Contractors shall continue to follow previous instructions for claims with dates of service in CY2006.	X		X	X		X						

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I I E R	C A R R I E R	D M R C	R M H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	CWF	
5478.1.2	The contractor shall grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in IOM Pub. 100-04, chapter 5, Section 10.2, for CY2007.											
5478.2	Contractors shall inform providers regarding theCY2007 process to request exceptions to the therapy financial limitations using the KX modifier, as described in Medicare manuals 100-02, 100-04, and 100-08.	X		X	X		X					
5478.3	Contractors shall continue in CY2007 to override CWF rejects indicating that a therapy service has exceeded the financial limitation and shall pay for the service if otherwise covered and payable when the claim contains a KX modifier.	X		X	X		X					
5478.4	Contractors shall discontinue the tracking and reporting requirements regarding the therapy financial limitation exceptions created in CR 4364 (Transmittal R52BP, R140PI, and R855CP).	X		X	X		X					
5478.5	Contractors shall subject therapy claims reporting the KX modifier to pre- or post-payment medical review as is consistent with their medical review strategy.	X		X	X		X					
5478.6	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 CY2007.	X		X	X		X					
5478.7	When reviewing claims for services excepted from therapy caps the contractor shall deny the claim where there is evidence of misrepresentation of facts presented	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I M I E R	C A R R I E R	D M R E C	R M H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	CWF	
	to the contractor by that provider in CY2007.											
5478.8	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		X					
5478.9	Contractors shall not accept requests for manual process exceptions for services provided in CY2007.	x		x	x		x					
5478.9.1	Contractors have discretion as to whether and how to respond to a request for manual process exception for services provided in CY 2007.	X		X	X		X					
5478.10	The contractor shall track workload associated with the Therapy Cap process inCY2007 only to the extent they would normally track workload as part of an activity (e.g., claims processing).	X		X	X		X					
5478.11	The contractor shall track costs associated with the Therapy Cap process in CY2007 only to the extent they would normally track workload as part of an activity (e.g., claims processing..	X		X	X		X					
5478.12	If unexpected costs related to the exceptions process occur, contractors shall report costs and workload in the line that best reflects the work being performed per the activity dictionary.	X		X	X		X					
5478.13	For CY2007, carriers and fiscal intermediaries shall not report the therapy cap costs and workload.	X		X	X		X					
5478.14	Contractors shall continue to enforce LCDs, since the presence of a KX does not supersede a Local Coverage Determination (LCD) in CY2007.	X		X	X		X					
5478.15	Contractors shall allow automatic	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I I E R	C A R R I E R	D M R C	R M H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	CWF	
	process exceptions for documented medically necessary services when any condition or complexity occurs regardless of whether it is represented <u>on the list</u> in Pub. 100-04, chapter 5, section 10.2 in CY2007.											
5478.16	Contractors shall update the list of exceptions inCY2007 according to the changes provided in this CR. Note that contractors may expand, but not remove ICD-9s from the where they believe further exceptions should be allowed.	X		X	X		X					
5478.17	Contractors shall allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year inCY2007.	X		X	X		X					
5478.18	Contractors shall NOT utilize the KX modifier in data analysis as the sole indicator of services that do exceed caps inCY2007. For all claims, there may be services with appropriately used KX modifiers that do not represent services that exceed the cap.	X		X	X		X					
5478.19	Contractors shall utilize consistently the new definitions and examples provided in this transmittal for Pub. 100-02, chapter 15, section 10.2.	X		X	X		X					
5478.20	Contractors shall not require the additional documentation that is encouraged but not required in Pub. 100-02, chapter 15, section 10.2.	X		X	X		X					
5478.21	Contractors shall require that documentation for outpatient therapy services include objective, measurable patient function information, either by using one of the four recommended (but not required) measurement tools, or	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I I C	C A R I E R	D M R C	R H R I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	CWF		
	other information as described in Pub 100-02, chapter 15 section 220.3C.											
5478.22	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay CY2007 claims between 1/1/2007 and the implementation date of this Change Request. However, contractors shall reopen and/or adjust CY2007 claims between 1/1/2007 and the implementation date of this CR when they are brought to their attention.	X		X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I I C	C A R I E R	D M R C	R H R I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	CWF		
5478.23	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 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	X		X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I	C A R I E R	D M R E C	R H H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	CWF	
	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

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5478.9	Contractors should note that the manual process for granting exceptions has been removed from the Medicare manuals.
5478.12	CMS does not anticipate any costs associated with the therapy caps process in CY2007.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne (claims processing) 410-786-6148, Dorothy Shannon 410-786-3396 (payment policy) or Dan Schwartz (program integrity) 410-786-4197.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. For TITLE XVIII Contractors, use only one of the following statements:

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

B. For Medicare Administrative Contractors (MAC), use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

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

(Rev.63, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

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/>.

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

CERTIFICATION is the physician's/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. *Services that require the skills of a therapist, may be appropriately furnished by clinicians, that is, by or under the supervision of qualified physicians/NPPs when their scope of practice, state and local laws allow it and their personal professional training is judged by Medicare contractors as sufficient to provide to the beneficiary skills equivalent to a therapist for that service.*

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

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

The EPISODE of Outpatient Therapy – For the purposes of therapy policy, an outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under the care of 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. *Skills of a therapist are defined by the scope of practice for therapists in the state).*

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

Therapy services referred to in this 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
- Ch 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
 - 30.4. - Direct Skilled Rehabilitation Services to Patients
 - 40 - Physician Certification and Recertification
 - 50.3 - Physical, Speech, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements with the Facility and Under Its Supervision
 - 70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services
- Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL
 - Part 1
 - 20.10 - Cardiac Rehabilitation Programs
 - 30.1 - Biofeedback Therapy
 - 30.1.1 - Biofeedback Therapy for the Treatment of Urinary Incontinence
 - 50.1 – Speech Generating Devices
 - 50.2 - Electronic Speech Aids
 - 50.4 - Tracheostomy Speaking Valve
 - Part 2
 - 150.2 - Osteogenic Stimulator
 - 150.4 - Neuromuscular Electrical Stimulator (NMES) in the Treatment of Disuse Atrophy
 - 160.3 - Assessing Patient’s Suitability for Electrical Nerve Stimulation
 - 160.7 - Electrical Nerve Stimulators
 - 160.11 - Osteogenic Stimulation
 - 160.12 - Neuromuscular Electrical Stimulation (NMES)
 - 160.13 - Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)
 - 160.17 - L-Dopa
 - Part 3
 - 170.1 - Institutional and Home Care Patient Education Programs
 - 170.2 - Melodic Intonation Therapy
 - 170.3 - Speech Pathology Services for the Treatment of Dysphagia
 - 180 - Nutrition
 - Part 4

230.8 - Non-implantable Pelvic Flood Electrical Stimulator
 240.7 - Postural Drainage Procedures and Pulmonary Exercises
 270.1 -Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds
 270.4 - Treatment of Decubitus Ulcers
 280.3 - Specially Sized Wheelchairs
 280.4 - Seat Lift
 280.5 - Safety Roller
 280.9 - Power Operated Vehicles That May Be Used as Wheelchairs
 280.13 - Transcutaneous Electrical Nerve Stimulators (TENS)
 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
 - 3.4.1.1.1 Exception From the Uniform Dollar Limitation (“Therapy Cap”)*
 - 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. [*100-02, chapter 15, §230*](#);
- 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.

220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services

(Rev. 63, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

References: Pub. 100-08, chapter 13, §13.5.1,
42CFR410.59,
42CFR410.60

A. General

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

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

Examples of coverage policies that apply to all outpatient therapy claims are in this chapter, in Pub. 100-04, chapter 5, and Pub. 100-08, chapter 13. Some policies in other manuals are repeated here for emphasis and clarification. *Further details on documenting reasonable and necessary services are found in section 220.3 of this chapter.*

B. Reasonable and Necessary

To be considered reasonable and necessary the following conditions must each be met. *(This is a representative list of required conditions and does not fully describe reasonable and necessary services. See the remainder of this section and associated information in section 230.):*

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:
 - Medicare manuals (such as this manual and Publications 100-03 and 100-04),
 - Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd>, and
 - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and

effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.
- While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See item C for descriptions of skilled (rehabilitative) services.
- There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

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

C. Rehabilitative Therapy

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

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

Evaluations; reevaluations

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

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

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

Instruction leading to establishment of compensatory skills;

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

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

Skilled Therapy. Rehabilitative therapy occurs when the skills of a therapist, (*See definition of therapist in section 220 of this chapter*) are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. (*See also section 220.3 of this chapter for documenting skilled therapy.*)

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

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

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

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

Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered. (See exceptions for maintenance in §220.2D of this manual).

D. Maintenance Programs

During the last visits for rehabilitative treatment, the *clinician* may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized *skill*, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan. The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.

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

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

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

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

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

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

220.3 - Documentation Requirements for Therapy Services

(Rev.63, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

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. *(See also section 220.2- Reasonable and Necessary Outpatient Rehabilitation Therapy Services)*

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

B. Documentation Required

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

- 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
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for *services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.*

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

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

Dates for Documentation. The date the documentation was made is important only to establish the date of the initial 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 *1* week of the last date to which the Progress Report or Treatment Note refers. For example, if treatment began on the first of the month at a frequency of twice a week, a Progress Report would be required at the end of the month. Contractors may require that the Progress Report that describes that month of treatment be dated not more than *1* week after the end of the month described in the report.

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

- 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, other 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.
- *Services are of appropriate type, frequency, intensity and duration for the individual needs of the patient.*
 - *Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.*
 - *Clinicians and contractors shall determine typical services using published professional literature and professional guidelines. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Services that exceed those typically billed should be carefully documented to justify their necessity, but are payable if the individual patient benefits from medically necessary services. Also, some services or episodes of treatment should be less than those typically billed, when the individual patient reaches goals sooner than is typical.*

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

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

C. Evaluation/Re-Evaluation and Plan of Care

The initial evaluation, or the plan of care including an evaluation, should document the necessity for a course of therapy through objective findings and subjective patient self-reporting. Utilize the guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language and Hearing Association as guidelines, and not as policy. Only a clinician may perform an initial examination, evaluation, re-evaluation and assessment or establish a diagnosis or a plan of care. A clinician may include, as part of the evaluation 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.

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

Evaluation shall include:

- 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;

- ***Results of one of the following four measurement instruments are recommended, but not required:***
 - *National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association*
 - *Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO)*
 - *Activity Measure – Post Acute Care (AM-PAC)*
 - *OPTIMAL by Cedaron through the American Physical Therapy Association*

- ***If results of one of the four instruments above is not recorded, the record shall contain instead the following information indicated by asterisks (*) and should contain (but is not required to contain) all of the following, as applicable. Since published research supports its impact on the need for treatment, information in the following indented bullets may also be included with the results of the above four instruments in the evaluation report at the clinician’s discretion. This information may be incorporated into a test instrument or separately reported within the required documentation. If it changes, update this information in the re-evaluation, and/or Treatment Notes, and/or Progress Reports, and/or in a separate record. When it is provided, contractors shall take this documented information into account to determine whether services are reasonable and necessary.***
 - ***Documentation supporting illness severity or complexity including, e.g.,***
 - *Identification of other health services concurrently being provided for this condition (e.g., physician, PT, OT, SLP, chiropractic, nurse, respiratory therapy, social services, psychology, nutritional/dietetic services, radiation therapy, chemotherapy, etc.), and/ or*
 - *Identification of durable medical equipment needed for this condition, and/or*
 - *Identification of the number of medications the beneficiary is taking (and type if known); and/or*
 - *If complicating factors (complexities) affect treatment, describe why or how. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but in some patients such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception*

to caps for necessary services. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient's condition as reported on a functional measurement tool may be so great as to suggest extended treatment is anticipated; and/or

- *Generalized or multiple conditions. The beneficiary has, in addition to the primary condition being treated, another disease or condition being treated, or generalized musculoskeletal conditions, or conditions affecting multiple sites and these conditions will directly and significantly impact the rate of recovery; and/or.*
- *Mental or cognitive disorder. The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery; and/or.*
- *Identification of factors that impact severity including e.g., age, time since onset, cause of the condition, stability of symptoms, how typical/atypical are the symptoms of the diagnosed condition, availability of an intervention/treatment known to be effective, predictability of progress.*
- ***Documentation supporting medical care prior to the current episode, if any, (or document none) including, e.g.,***
 - *Record of discharge from a Part A qualifying inpatient, SNF, or home health episode within 30 days of the onset of this outpatient therapy episode, or*
 - *Identification of whether beneficiary was treated for this same condition previously by the same therapy discipline (regardless of where prior services were furnished; and*
 - *Record of a previous episode of therapy treatment from the same or different therapy discipline in the past year.*
- ***Documentation required to indicate beneficiary health related to quality of life, specifically,***
 - *The beneficiary's response to the following question of self-related health: "At the present time, would you say that your health is excellent, very good, fair, or poor?" If the beneficiary is unable to respond, indicate why; and*
- ***Documentation required to indicate beneficiary social support including, specifically,***
 - *Where does the beneficiary live (or intend to live) at the conclusion of this outpatient therapy episode? (e.g., private home, private apartment, rented room, group home, board and care apartment, assisted living, SNF), and*
 - *Who does beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode? (e.g., lives alone,*

spouse/significant other, child/children, other relative, un related person(s), personal care attendant), and

- *Does the beneficiary require this outpatient therapy plan of care in order to return to a premorbid (or reside in a new) living environment, and*
- *Does the beneficiary require this outpatient therapy plan of care in order to reduce Activities of Daily Living (ADL) or Instrumental Activities of Daily Living or (IADL) assistance to a premorbid level or to reside in a new level of living environment (document prior level of independence and current assistance needs); and*
- ****Documentation required to indicate objective, measurable beneficiary physical function including, e.g.,***
 - *Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or*
 - *Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or*
 - *Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.*

- 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.

NOTE: When the Evaluation Serves as the Plan of Care. When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, intensity and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. A referral/order dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient.

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

Re-evaluations shall be included in the documentation sent to contractors when a re-evaluation has been performed. See the definition in section 220. Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, 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 Report 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 7 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 Reports may be written in the Treatment Notes if the provider/supplier or clinician prefers. If each element required in a Progress Report is included in the Treatment Notes at least once during the Progress Report Period, then a separate Progress Report is not required. Also, elements of the Progress Report may be incorporated into a revised Plan of Care. 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 Treatment Note and/or on the Progress Report. When unexpected discontinuation of treatment occurs, contractors shall not require a clinician's participation in treatment for the incomplete reporting period.

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

shall include all treatment provided since the last Progress Report and indicate that the therapist reviewed the notes and agrees to the discharge.

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

Assistant's Participation in the Progress Report

Physical Therapist Assistants or Occupational Therapy Assistants may write elements of the Progress Report dated between clinician reports. Reports written by assistants are not complete Progress Reports. The clinician must write a Progress Report during each Progress Report Period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the clinician's 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 Report may be used to add, change or delete short term goals. Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name, and date. Clinicians verify these changes by cosignatures on the report or in the clinician's Progress Report. (See section 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, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current Progress Report Period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3,) and the short term goals that relate to the long term goals may be numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. A clinician, an assistant on the order of a therapist or qualified personnel on the order of a physician/NPP shall add new goals with new identifiers or letters. Omit reference to a goal after a clinician has reported it to be met, and that clinician's signature verifies the change.

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

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

- 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 Notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff may be reported voluntarily as additional information if they are relevant and not billed. Specifics such as number of repetitions of an exercise and other details included in the plan of care need not be repeated in the Treatment Notes unless they are changed from the plan.

Documentation of each Treatment shall include the following required elements:

- 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. The 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 Progress Reports, the change must be recorded and justified on the medical record, either in the Treatment note or the Progress Report, as determined by the policies of the provider/supplier. New exercises added or changes made to *the* 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.

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

(Rev.63, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

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

B. Therapy Students

1. General

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

EXAMPLES:

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

- *The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.*
- *The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.*

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

2. Therapy Assistants as Clinical Instructors

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

3. Services Provided Under Part A and Part B

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