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FACT SHEET
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Complying with Outpatient Rehabilitation Therapy Documentation Requirements



What's Changed?

Starting January 1, 2025, we allow the physician or non-physician practitioner (NPP) written order or referral to substitute for the signature on the initial plan of care (POC) certification (pages 4 and 5).

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®
CERT A/B MAC OUTREACH & EDUCATION Task Force for Error-Free Medicare Claims

In this fact sheet, **you** refers to the provider or supplier, and **we** refers to CMS.

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to medical record documentation. It's designed to help providers understand how to submit accurate and supporting documentation for outpatient rehabilitation therapy services.

We use the CERT Program to measure improper payments in the Medicare Fee-for-Service (FFS) Program. Under CERT, we review a random sample of Medicare FFS claims to determine if we paid them correctly under Medicare coverage, coding, and billing rules.

Once the CERT Program identifies a claim in the sample, it requests (via fax, letter, or phone call) the associated medical records and other related documentation from the provider or supplier who submitted the claim. CERT medical review professionals then examine the claim and related documentation.

Definitions

Physician is a doctor of medicine, osteopathy, podiatric medicine, or optometry (only for low vision rehabilitation).

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

Qualified therapist includes a physical therapist (PT), occupational therapist (OT), or speech-language pathologist (SLP) who meets regulatory qualifications as applicable, including state licensure or certification. Medicare Benefit Policy Manual Chapter 15, sections 230.1–230.3, has more information.

Billing Medicare Part B Outpatient Therapy Services

Outpatient rehabilitation therapy includes physical therapy, occupational therapy, and speech-language pathology services, which we cover when the:

- Physician or NPP certifies the treatment plan, also called the plan of care (POC), making sure the:
  - Patient needs therapy services
  - Patient gets services under a physician's or NPP's care
  - POC is:
    - Established by a physician, NPP, or qualified therapist providing the services
    - Reviewed periodically by a physician or NPP
- POC-certifying provider's name and NPI is on the claim
- Providers meet documentation and coding requirements
- Claim meets medical necessity requirements

Common Outpatient Rehabilitation Therapy CERT Errors

Error	Prevention
Missing certification and recertifications Physician's or NPP's dated signatures approving the POC	Confirm the physician or NPP certified the POC (and recertified it when appropriate) with their signature and date. Starting January 1, 2025, for therapist-established POCs, the physician's or NPP's dated signature on the order or referral may be substituted for a signature on the initial POC if that physician or NPP hasn't signed and returned the patient's POC to the therapist within 30 calendar days of the initial evaluation. This applies only when the patient's physician or NPP signs and dates the written order or referral, including information to identify the physician or NPP as well as the patient, and indicates the type of therapy needed, for example, physical therapy, occupational therapy, or speech-language pathology services. Documentation requirements are met for this "exception to the signature requirement" on the initial POC when the patient's medical record includes that written order or referral, along with further evidence that the POC was delivered to the physician or NPP within 30 calendar days of the therapist's initial evaluation. This policy doesn't apply to recertifications or to POCs in a comprehensive outpatient rehabilitation facility (CORF).
Missing signature Physician, NPP, or therapist who developed the POC and established the POC date	Make sure you add your dated signature and professional identification (for example, PT, OT registered or licensed (R/L)) on the POC you established.
Missing or incomplete POC	Create a complete POC that includes diagnoses, long-term goals, and service type, amount, frequency, and duration.
Missing significant POC changes Certifications and recertifications	Certify a significantly modified POC (the physician or NPP signs and dates it).
Missing total time For timed code treatment minutes and total treatment time	Clearly document the total minutes for timed code treatment to support the number of units and codes billed for each treatment day, and document the total minutes of treatment time (including timed and untimed codes) in the patient's medical record.
Missing or incomplete initial evaluation	Document the initial evaluation with your signature, professional identification (for example, PT, OTR/L), and date of your initial evaluation (Medicare Benefit Policy Manual, Chapter 15, section 220.3 has more information).

Common Outpatient Rehabilitation Therapy CERT Errors (cont.)

Error	Prevention
Missing or incomplete progress reports	Progress reports justify medical necessity and require information like timing (at least once every 10 treatment days) and include your signature, professional identification, and date (Medicare Benefit Policy Manual, Chapter 15, section 220.3 has more information)
Missing elements supporting medical necessity	Medicare Benefit Policy Manual, Chapter 15, sections 220 and 230 have more information

Note: If your Medicare Administrative Contractor identifies a potential outpatient therapy Part B claim overpayment within 6 years of getting the overpayment (generally referred to as the "lookback period"), you must report and return all identified overpayments. Section 1128J(d) of the Social Security Act has more information.

Outpatient Rehabilitation Therapy Services Documentation

Written POC

The services must relate directly and specifically to a written treatment plan (also called a POC). You must establish the POC before treatment starts, with some exceptions. A physician, NPP, PT, OT, or SLP may develop (written or dictated) a POC. Only a physician may establish a POC in a CORF.

At a minimum, the POC must have:

- **Diagnoses**
- **Long-term treatment goals**
- **Rehabilitation therapy service types:** May be physical therapy, occupational therapy, or speech-language pathology, or, when appropriate, may be a description of a specific treatment or intervention for a specific discipline
- **Therapy amount:** Number of treatment sessions per day
- **Therapy frequency:** Number of treatment sessions per week
- **Therapy duration:** Total number of weeks or treatment sessions

Include the signature and professional identity of the person who established the POC and the date it was established. Document the physician's or NPP's written or verbal approval, and any significant or long-term goal change (for example, when treating a new condition) to the already certified POC. Each POC should offer the most effective and efficient treatment and balance appropriate resources to provide the best possible outcomes.

Initial POC Certification

The physician's or NPP's signature and date on a correctly written POC satisfies the certification requirement during the POC or 90 calendar days from the initial treatment date, whichever is less. The POC must be consistent with the related evaluation, which is considered incorporated into the POC.

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

Starting January 1, 2025, for therapist-established POCs, the physician's or NPP's dated signature on the order or referral may be substituted for a signature on the initial POC if that physician or NPP hasn't signed and returned the patient's POC to the therapist within 30 calendar days of the initial evaluation. This applies only when the patient's physician or NPP signs and dates the written order or referral, including information to identify the physician or NPP as well as the patient, and indicates the type of therapy needed, for example, physical therapy, occupational therapy, or speech-language pathology services. Documentation requirements are met for this "exception to the signature requirement" on the initial POC when the patient's medical record includes that written order or referral, along with further evidence that the POC was delivered to the physician or NPP within 30 calendar days of the therapist's initial evaluation. This policy doesn't apply to recertifications or to POCs in a CORF.

Recertification

The physician or NPP signs recertifications documenting the need for continued or modified therapy whenever a significant POC modification becomes evident, or at least every 90 calendar days after treatment starts.

The physician or NPP completes recertification sooner when the plan duration is less than 90 calendar days unless a certification delay occurs. We allow delayed certification when the physician or NPP completes certification and includes a delay reason. We accept certifications without justification up to 30 calendar days after the due date. Recertification is timely when dated during the initial POC or within 90 calendar days of the initial POC, whichever is less.

Billing Procedure Units

When reporting "untimed service units" HCPCS codes (the procedure is undefined by specific time frame), report **1** in the unit field (for example, therapy evaluations, group therapy, and supervised modalities HCPCS codes).

The 15-minute timed codes are defined as requiring the physician, NPP, or therapist to have direct 1-on-1 patient contact. We use total timed code treatment time to determine the number of units these timed codes can be reported per discipline for each date, regardless of the number of different treatments provided. See Medicare Claims Processing Manual, Chapter 5, section 20.2.C for information about counting minutes for timed codes in 15-minute units.

Document the total minutes for timed code treatment in the patient's medical record for each service date to support the number of units and codes billed. Also, report total treatment service minutes, including timed and untimed procedures or modalities.

Therapy Modifier Requirements

All outpatient therapy service claims must report a therapy modifier (GP, GO, or GN) with the HCPCS code to show the treatment plan discipline (physical therapy, occupational therapy, or speech-language pathology). Certain HCPCS codes require certain therapy modifiers. To see the HCPCS codes that require a GP, GO, or GN modifier, see the list of therapy codes on Annual Therapy Update.

Therapy assistant services modifiers include:

- **CQ:** Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- **CO:** Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

Use the CQ or CO modifier along with the respective GP or GO modifier, for the services provided in whole or in part by a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when the PTA or OTA provides more than 10% of a service, known as the 10% standard or the de minimis standard.

We make payment for claims with the CQ or CO modifier at 85% of the otherwise applicable Part B payment for dates of service on and after January 1, 2022. Change Request 12397 has more information.

We finalized these policies in the CY 2022 Physician Fee Schedule (PFS) final rule that identify when the CQ and CO modifiers apply and when they don't apply:

- Use the CQ and CO modifiers when the PTA or OTA wholly provides services independent of the PT or OT. The CQ or CO modifiers also generally apply when the minutes provided by the PTA or OTA, independent of any minutes provided by the PT or OT for the same service, timed or untimed, exceed 10% of the total minutes for that service.
- Don't use the CQ and CO modifiers when either:
  - A PT or OT wholly provides a service
  - A PT and PTA or an OT and OTA, together, provide care to a patient at the same time

In the CY 2022 PFS final rule, we define 2 exceptions where the 10% standard doesn't apply:

- If there's 1 final 15-minute unit (of a multi-unit scenario) left to bill for a given treatment day, don't apply the CQ or CO modifier when the PT or OT meets the Medicare billing requirements for the final 15-minute timed service, without the minutes provided by the PTA or OTA, by providing more than the 15-minute midpoint (for example, 8 minutes or more)
- In cases where 2, 15-minute units remain to be billed, and the PT or OT and the PTA or OTA each provide between 9 and 14 minutes of the same service where the total time is at least 23 minutes and no more than 28 minutes, bill:
  - One unit with the CQ or CO modifier for the minutes provided by the PTA or OTA
  - The other unit without the CQ or CO modifier for the minutes provided by the PT or OT

For more information on using the CQ and CO modifiers, including billing scenarios and how to calculate the 10% standard, see Billing Examples Using CQ/CO Modifiers for Services Furnished In Whole or In Part by PTAs and OTAs.

Correctly Using Timed & Untimed Codes

When you provide only 1, 15-minute timed HCPCS code per day, you can't bill that service if you did it for less than 8 minutes. When providing more than 1 unit of service, the first 15-minute service and, if applicable, any subsequent units you provide before the last unit, must each total at least 15 minutes, and the last unit counts as a full 15-minute unit if you provided at least 8 minutes (that is, more than the 7.5 minute midpoint) of additional services. This is also known as the 8-minute rule. Don't count all minutes per day to 1 HCPCS code if you provide other services for more than 15 minutes.

If a therapist provides 4 distinct, separate 8-minute treatments (32 treatment minutes total), don't report 4, 15-minute treatment units on the claim. In this case, you may report only 2 units (at least 23 minutes but less than 38 minutes). You may report a third unit when you provide a total of 38–52 minutes, and you may bill a fourth unit if you provide at least 53 but less than 68 treatment minutes. **Don't report units on the claim that exceed the total timed codes' treatment minutes.**

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

Medicare Claims Processing Manual, Chapter 5, section 20.2, has more information about HCPCS coding requirements, including examples correctly showing 15-minute codes when providing 1 or multiple therapy services, procedures, and modalities per day.

Resources

- Complying with Medicare Signature Requirements
- CY 2025 Physician Fee Schedule Final Rule for policies related to POCs with a Physician or NPP Order or Referral (89 FR 97912 through 97918)
- Local Coverage Determinations
- Medicare Benefit Policy Manual, Chapter 12, sections 20 and 30
- Medicare Benefit Policy Manual, Chapter 15, sections 220 and 230
- Medicare Claims Processing Manual, Chapter 5, section 20
- Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, section 10.3
- Medicare Program Integrity Manual, Chapter 3, section 3.3.2.4
- Medicare Program Integrity Manual, Chapter 12
- Therapy Services



The Medicare Learning Network® and the Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Force developed this content to provide nationally consistent education to health care providers.

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