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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or C-M-S. These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for Medicare Fee-For-Service Providers.

If you are a Medicare Fee-For-Service Provider who submits claims to Medicare Administrative Contractors, or MACs, or Medicare carriers, you will benefit from this podcast!

It will give you information to help you comply with documentation requirements for Outpatient Rehabilitation Therapy Services for Medicare beneficiaries. If you are a physician or treating practitioner who prescribes outpatient rehabilitation therapy services for Medicare beneficiaries, you will also benefit from this podcast.

This podcast is based on the Medicare Learning Network®, or M-L-N, fact sheet titled "Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements." CMS issued the fact sheet to help Medicare physicians and non-physician practitioners comply with Federal law and documentation requirements before ordering outpatient rehabilitation therapy services for Medicare beneficiaries. The fact sheet also describes common Comprehensive Error Rate Testing, or CERT, Program errors related to outpatient rehabilitation therapy services.

In order to accurately measure the performance of Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates both a national Medicare Fee-For-Service paid claims error rate and a provider compliance error rate. The results of these reviews are published in an annual report and semi-annual updates.
CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare Trust Funds and protect beneficiaries.

You should consider this important information and take the necessary steps to meet Medicare requirements. Please note, this podcast and the related fact sheet are intended as educational guides and do not ensure compliance with Medicare regulations.
Let's begin our discussion today with four (4) types of errors identified through the CERT Review Process for outpatient rehabilitation therapy services:

- First, Missing/"or" incomplete plan of care/"or" treatment plan;
- Second, Missing physician/"or" Non-Physician Practitioner (NPP) signatures and dates;
- Third, Missing total time for procedures and modalities; and
- Fourth, Missing certification and re-certification documentation.

Now we'll discuss the required documentation for each of the errors we just identified.

First, we will begin with the Written Treatment Plan/"or" Plan of Care .

Outpatient rehabilitation therapy services must relate **directly and specifically** to a written treatment plan. This is also known as the plan of care or plan of treatment and must be established before

treatment begins, with some minor exceptions. The plan of care is established when it is written or dictated by a physician, NPP, physical therapist, occupational therapist, or speech-language pathologist.

At a minimum, the plan of care should contain the following six (6) items:

- Diagnoses;
- Long-term treatment goals;
- Type of rehabilitative therapy services for each service you are providing. That is, physical therapy, occupational therapy, or speech-language therapy. Identify each specific intervention, procedure or modality, so you can support billing and verify correct coding;
- Amount of therapy; that is, the number of treatment sessions in a day;
- Duration of therapy; that is, the number of weeks or number of treatment sessions; and Frequency of therapy; that is, the number of treatment sessions needed for the beneficiary in a week.

Next we will discuss missing physician, non-physician practitioner, signatures and dates.
The signature and the professional identity of the person establishing the plan of care, and the date of the plan of care must be documented. The physician "or" non-physician practitioner certification is required if significant changes are needed to the plan of care.
The plan of care should provide treatment in the most effective and efficient manner for the best achievable outcome.

We will now address a few points about timeliness of the Initial Certification of the Plan of Care.
The physician's or NPP's certification (with or without an order) satisfies all of the certification requirements for the duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan of care.

Timely certification is met when the physician "or" non-physician practitioner certification of the plan of care is documented, either by signature or verbal order, and dated within 30 days following the first day of treatment (including the evaluation). Verbal orders must be followed within 14 days by a signature and date.

Recertification, or documenting the need for continued or modified therapy, should be signed whenever the need for a significant modification of the plan of care is needed, or at least every 90 days after initiation of treatment under the plan of care, unless the certification is delayed. Recertification is required sooner when the duration of the plan of care is less than 90 days.

Next, we will discuss billing procedure and modality units. Many Healthcare Common Procedure Coding System (or [pronounced] "HICPICKS") codes where the procedure is not defined by a specific time frame **(or "untimed"), use "1" (one)** in the unit field. For example, [HCPCS] HICPICKS codes for therapy evaluations, group therapy, and supervised modalities. However, a few untimed codes, "add-on" codes, for example, are reported based on the number of times the procedure is performed. (One example is an add-on HICPiCKS debridement code billed, in addition to its "base" code, for each additional 20 square centimeters of tissue removed.)

Some HCPCS codes specify that direct (one-on-one) time spent in beneficiary contact is 15 minutes. In those cases, the units are the appropriate number of 15-minute units of services. When only one service

is provided in a day, a service performed for less than 8 minutes should not be billed. When more than one unit of service is provided, the initial and subsequent services must total at least 15 minutes, and the last unit may be counted as a full unit of service if the beneficiary received at least eight minutes of additional service.

Total treatment minutes of the beneficiary, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, **must be documented.**

Remember, to avoid a CERT error, check your medical record documentation and claims submission practices to ensure you address the following four (4) areas:

- **One,** Create a complete plan of care, making certain to include your signature, professional identification, for example, Physical Therapist or Licensed Occupational Therapist, and the date the plan was established.
- **Two,** Document when the plan of care is modified, including how it is modified and why the previous goals were not met or could not be met.
- **Three,** Confirm the plan of care is certified (recertified when appropriate) with physician/ "or" non-physician practitioner signature and date; and
- **Four,** Clearly document in minutes, the total treatment time for the timed codes and the total treatment time (including timed and untimed codes) in the beneficiary's record.

More questions? To learn more about documentation and coverage for Outpatient Rehabilitation Therapy Services contact your Medicare Contractor or visit our website at www.cms.gov/MLNGenInfo and follow the links to MLN Products and download the full fact sheet on this subject titled "**Outpatient Rehabilitation Therapy Services: Complying With Documentation Requirements."**

Please visit the MLN Provider Compliance web page at www.cms.gov/MLNProducts for educational Fee-For-Service provider materials to help you understand – and avoid – common billing errors.

Be on the lookout for future MLN podcasts on subjects of interest to you.