Therapy Reason Codes and Statements
November 3, 2021

Reason Code	PLAN OF CARE
TP000	The documentation submitted did not support a plan of care for the therapy service(s). Refer to Social Security Act (SSA) 1862; 42CFR§410.61(a), 42 CFR § 409.17, Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.1.2
TP001	Documentation does not support the plan of care was established and signed by a qualified clinician/practitioner. Refer to Social Security Act (SSA) 1861(p)(2); 42CFR§410.61(b), 42 CFR § 409.17, Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 15, Section 220.1.2A, MBPM, Chapter 15, Sections 220(A)
TP002	The documentation submitted did not support the approval/certification of the plan of care for the therapy service(s). Refer to Social Security Act (SSA) 1862; 42 CFR §424.24, Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3 A
TP003	Documentation does not support the initial plan of care was certified by the physician / NPP. There was no evidence of delayed certification or attempts to obtain certification from the physician / NPP. Refer to Social Security Act (SSA) 1862; 42 CFR §424.24 2c, Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3 B-D
TP004	The documentation submitted did not support the reason for delayed/lapsed (re)certification. Refer to Social Security Act (SSA) 1862; SSA §1835(a), 42CFR424.11(d)(3), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3 C-D
TP005	The plan of care did not contain the diagnoses or long-term goals. Refer to Social Security Act (SSA) 1862; 42CFR§410.61(c); 42 CFR § 409.17; Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.1.2B
TP007	Documentation does not support the Plan of Care was recertified within the duration of the prior plan of care, or within 90 days, whichever is less. Refer to 42 CFR §424.24 c(4)(i); Internet Only Manual (IOM), Publication 110-02 Medicare Benefit Policy Manual, Chapter 15, Section 220.1.3 D.
TP008	The documentation submitted did not support the rehabilitation plan of treatment was established and signed by the physician prior to the initiation of therapy services. Refer to 42 CFR §424.27, Internet Only Manual (IOM), Publication 110-02 Medicare Benefit Policy Manual, Chapter 12, Section 30 E. (This would be specific to CORF).

Reason Code	INITIAL EVALUATION
TP100	The documentation submitted did not include an initial evaluation to support the therapy service(s) billed. Refer to Social Security Act (SSA) 1862, Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.B-C
TP101	The documentation submitted did not include all the required elements of an initial evaluation including diagnosis or condition description to be treated, current objective measurable function, clinician's clinical judgments, prognosis for premorbid return, signature of qualified clinician. Refer to 42 CFR § 409.44 (c)(1)(iv), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.C; Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4

Reason Code	RE-EVALUATION
TP200	The documentation submitted did not support significant change in condition or unresponsiveness to therapy interventions to support need for clinical re-evaluation. Refer to 42 CFR § 409.44 (c)(2)(F), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.C

Reason Code	PROGRESS NOTES
TP300	The documentation submitted did not include a progress report which was completed. Refer to Internet 42 CFR § 409.44 (c)(2), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.D
TP301	The documentation submitted did not include a progress report which was either signed or signed by qualified staff. Refer to Internet 42 CFR § 409.44 (c)(2), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.D
TP302	The documentation submitted did not include a progress report which supported the reason(s) for continued service(s). Refer to Internet 42 CFR § 409.44 (c)(2), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.D
TP303	The documentation submitted did not include a progress report which was completed a minimum of every 10th treatment visit throughout the episode of care or within 7 calendar days from the end date of the reporting period. Refer to Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3. D

Reason Code	MEDICAL NECESSITY
TP400	The documentation submitted lacked evidence to support the ongoing skills of a qualified therapist were required to complete the treatment. Refer to Social Security Act (SSA) 1862, 42 CFR § 409.44 (c) (2), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2 A, 220.2 B
TP401	The documentation submitted did not support the initiation of therapy treatment services were medically necessary. Refer to Social Security Act (SSA) 1862, 42 CFR § 409.44 (c), Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2

Reason Code	TREATMENT NOTES
TP500	Documentation does not support that the treatment billed was completed by or appropriately supervised by a qualified clinician/professional. Refer to 42 CFR § 410.60 (a)(3), 42 CFR § 410.60 (c)(2), 42 CFR § 410.62 (c), Internet Only Manual (IOM), Pub 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 220.2.A, Medicare Benefit Policy Manual, Chapter 15, Section 230.1C and 230.2C.
TP501	Documentation did not include a treatment note which contained all the required elements including date of treatment, description of modality/procedure to support accurate billing, total treatment minutes/ total timed code treatment minutes and signature of qualified professional. Refer to Internet Only Manual (IOM), Publication 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.E, IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 5, Section 20.2 (B)(C), 20.3, Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4

Reason Code	DISCHARGE NOTE
TP600	The documentation did not include a therapy discharge note or summary. Refer to Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM), Pub 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 220.3. D

Reason Code	BILLING
TP700	The documentation submitted did not support the unit(s) billed. Refer to Internet Only Manual (IOM), Pub 100-4, Medicare Claims Processing Manual (MCPM), Chapter 5, Section 20.2.C

TP701	Educational note given to the provider, if the beneficiary is thought to have exceeded the therapy threshold then the claim should be billed with a KX Modifier. Refer to 42 CFR § 410.60 (e)(2), Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM), Pub 100-4, Medicare Benefit Policy Manual, Chapter 5, Section 10.3.3.

Reason Code	MISCELLANEOUS
TP800	Documentation submitted was illegible. Refer to Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3 A.
TP801	The ABN is invalid, incomplete or missing. Refer to Social Security Act (SSA) §1862(a)(1), Medicare Claims Processing Manual, Chapter 1, Section 60.1
TP802	The documentation submitted does not support the medical necessity as listed in coverage requirements. Refer to Social Security Act 1862(a)(1)(A), Internet-Only Manual, Pub 100-08, Chapter 3, Section 3.6.2.1, 3.6.2.2, Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.3.

Reason Code	INDIVIDUALS CONDUCTING THERAPY
TP900	The documentation supports a therapy student was involved in the care of the beneficiary without qualified practitioner presence. Refer to 42 CFR § 410.60, Internet Only Manual (IOM), 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 230B.
TP901	The documentation supports a therapy aide provided the service to the beneficiary. Refer to Social Security Act 1862(a)(1)(A), 42 CFR § 410.60, Internet Only Manual (IOM), 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 230.1C & 230.2C.
TP902	The documentation did not support appropriate billing of the CQ and/or CO modifier as services were not furnished in whole or in part by a therapy assistant. Refer to 42 CFR § 410.60 (a)(4), Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 5, Section 20.1.
TP903	The documentation supports the CQ and/or CO modifier should have been billed as services were furnished in whole or in part by a therapy assistant. Refer to 42 CFR § 410.60 (a)(4), Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 5, Section 20.1.

Reason Code	ADMINISTRATIVE/OTHER *(For Transmission via esMD)*
GEX04	Other
GEX05	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
GEX06	The documentation submitted is incomplete
GEX07	This submission is an unsolicited response
GEX08	The documentation submitted cannot be matched to a case/claim
GEX09	This is a duplicate of a previously submitted transaction
GEX10	The date(s) of service on the cover sheet received is missing or invalid.
GEX11	The NPI on the cover sheet received is missing or invalid.
GEX12	The state where services were provided is missing or invalid on the cover sheet received.
GEX13	The Medicare ID on the cover sheet received is missing or invalid.
GEX14	The billed amount on the cover sheet received is missing or invalid.
GEX15	The contact phone number on the cover sheet received is missing or invalid.
GEX16	The Beneficiary name on the cover sheet received is missing or invalid
GEX17	The Claim number on the cover sheet received is missing or invalid
GEX18	The ACN on the coversheet received is missing or invalid
GEX19 (Effective 10/01/2021)	Provider is exempted from submitting this PA request