CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 194	**Date: September 3, 2014**
	Change Request 8605

Transmittal 181, dated March 14, 2014, is being rescinded and replaced by Transmittal 194 to change the effective and implementation dates for ICD-10. Also, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. All other information remains the same.

SUBJECT: Pub. 100-02 Language-Only Update for ICD-10

I. SUMMARY OF CHANGES: This transmittal updates Pub. 100-02 to make language-only changes related to conversion to ICD-10. The only chapters in Pub.100-02 that require such update are Chapters Two, Six, and Fifteen. All three chapters are included in this CR. The change in coding systems for Medicare claims and the specific ICD-10-CM codes in this update have been announced previously in various communications.

EFFECTIVE DATE: Upon Implementation of ICD-10
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: Upon Implementation of ICD-10

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	2/20/Admission Requirements
R	6/70.3/Partial Hospitalization Services
R	15/50.6/Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home
R	15/220/Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
R	15/220.3/Documentation Requirements for Therapy Services
R	15/280.1/Glaucoma Screening
R	15/280.2.3/Determining Whether or Not the Beneficiary is at High Risk for Developing Colorectal Cancer

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/280.4/Screening Pap Smears
R	15/310.3/Limitations for Coverage

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 194	Date: September 3, 2014	Change Request: 8605

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SUBJECT: Pub. 100-02 Language-Only Update for ICD-10

EFFECTIVE DATE: Upon Implementation of ICD-10
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: Upon Implementation of ICD-10

I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ICD-10 language in Pub 100-02.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8605.1	All MACs shall be aware of the conversion to ICD-10 effective for services upon implementation of ICD-10.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

Medicare Benefit Policy Manual
Chapter 2 - Inpatient Psychiatric Hospital Services

20 - Admission Requirements
(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

For all IPFs, a provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnosis of comorbid diseases as well as the psychiatric diagnosis.

In addition, according to 42 CFR 412.27(a) and 42 CFR 482.61, distinct part psychiatric units of acute care hospitals and CAHs are required to admit only those patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five of the International Classification of Diseases *applicable to the service date*. Psychiatric hospitals are required to be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons, according to 42 CFR 412.23(a).

Medicare Benefit Policy Manual
Chapter 6 - Hospital Services Covered Under Part B

70.3 - Partial Hospitalization Services
(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

A. Program Criteria

PHPs work best as part of a community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served. PHPs may be covered under Medicare when they are provided by a hospital outpatient department or a Medicare-certified CMHC.

Partial hospitalization is active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient, and includes a multidisciplinary team approach to patient care under the direction of a physician. The program reflects a high degree of structure and scheduling. According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a PHP.

B. Patient Eligibility Criteria

1. Benefit Category

Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization and require a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care. The patients also require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature. In addition, PHP patients must be able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of a PHP program.

Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued

inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP. Recertification must address the continuing serious nature of the patients' psychiatric condition requiring active treatment in a PHP.

Discharge planning from a PHP may reflect the types of best practices recognized by professional and advocacy organizations that ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.

2. Covered Services

Items and services that can be included as part of the structured, multimodal active treatment program, identified in §1861(ff)(2) include:

- Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);

- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physicians treatment plan for the individual;

- Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;

- Drugs and biologicals that cannot be self administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);

- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;

- Family counseling services for which the primary purpose is the treatment of the patient's condition;

- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individuals care and treatment of his/her diagnosed psychiatric condition; and

- Medically necessary diagnostic services related to mental health treatment.

Partial hospitalization services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements in or of §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).

3. Reasonable and Necessary Services

This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individual's

condition and functional level and prevent relapse or hospitalization. A particular individual covered service (described above) as intervention, expected to maintain or improve the individual's condition and prevent relapse, may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting, must have an adequate support system to sustain/maintain themselves outside the PHP and must not be an imminent danger to themselves or others. Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or listed in Chapter 5, of the *version of* the International Classification of Diseases (ICD) *applicable to the service date*, which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition.

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

Patients in PHP may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the patient's clinical condition improves or stabilizes and he/she no longer requires structured, intensive, multimodal treatment.

4. Reasons for Denial

a. Benefit category denials made under §1861(ff) or §1835(a)(2)(F) are not appealable by the provider and the limitation on liability provision does not apply (HCFA Ruling 97-1). Examples of benefit category based in §1861(ff) or §1835(a)(2)(F) of the Act, for partial hospitalization services generally include the following:

- Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;
- Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for the chronically mentally ill; or
- Patients who are otherwise psychiatrically stable or require medication management only.

b. Coverage denials made under §1861(ff) of the Act are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1). The following services are excluded from the scope of partial hospitalization services defined in §1861(ff) of the Social Security Act:

- Services to hospital inpatients;
- Meals, self-administered medications, transportation; and
- Vocational training.

c. Reasonable and necessary denials based on §1862(a)(1)(A) are appealable and the Limitation on Liability provision does apply. The following examples represent reasonable and necessary denials for partial hospitalization services and coverage is excluded under §1862(a)(1)(A) of the Social Security Act:

- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a PHP; or

- Treatment of chronic conditions without acute exacerbation of symptoms that place the individual at risk of relapse or hospitalization.

5. Documentation Requirements and Physician Supervision

The following components will be used to help determine whether the services provided were accurate and appropriate.

a. Initial Psychiatric Evaluation/Certification.--Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

b. Physician Recertification Requirements.--

- Signature – The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

- Timing – The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

- Content – The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:

  - The patient's response to the therapeutic interventions provided by the PHP;

  - The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization; and

  - Treatment goals for coordination of services to facilitate discharge from the PHP.

c. Treatment Plan.--Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued

need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

d. Progress Notes.--Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention and its relation to the goals indicated in the treatment plan.

See the Medicare Claims Processing Manual, Chapter 4, "Hospital Outpatient Services," §260 for billing instructions for partial hospitalization services.

Medicare Benefit Policy Manual
Chapter 15 – Covered Medical and Other Health Services

50.6 – Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

Beginning for dates of service on or after January 1, 2004, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home (ICD-9 diagnosis codes 279.04, 279.05, 279.06, 279.12, and 279.2 *or ICD-10-CM codes D80.0, D80.5, D81.0, D81.1, D81.2, D81.6, D81.7, D81.89, D81.9, D82.0, D83.0, D83.2, D83.8, or D83.9 if only an unspecified diagnosis is necessary)*. The Act defines "intravenous immune globulin" as an approved pooled plasma derivative for the treatment of primary immune deficiency disease. It is covered under this benefit when the patient has a diagnosed primary immune deficiency disease, it is administered in the home of a patient with a diagnosed primary immune deficiency disease, and the physician determines that administration of the derivative in the patient's home is medically appropriate. The benefit does not include coverage for items or services related to the administration of the derivative. For coverage of IVIG under this benefit, it is not necessary for the derivative to be administered through a piece of durable medical equipment.

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

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

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 1 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.

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 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 discipline in that setting.

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.

FUNCTIONAL REPORTING, which is required on claims for all outpatient therapy services pursuant to 42CFR410.59, 410.60, and 410.62, uses nonpayable G-codes and related modifiers to convey information about the patient's functional status at specified points during therapy. (See Pub 100-04, chapter 5, section 10.6)

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. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, reevaluations must also meet Medicare coverage guidelines. The decision to provide a reevaluation shall be made by a clinician.

INTERVAL of certified treatment (certification interval) consists of 90 calendar days or less, based on an individual's needs. A physician/NPP may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report period.

MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

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 furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (see section 230.1 and 230.2) and may not supervise other therapy caregivers.

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 *chapter*. 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 acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.3.2.4 concerning signatures.

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.

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 (PT), occupational therapy (OT) and speech-language pathology (SLP) 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 chapter are those skilled services furnished according to the standards and conditions in CMS manuals, (e.g., in this chapter and in Pub. 100-04, Medicare Claims Processing Manual, 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 Pub. 100-04, chapter 5, §20, and in Local Coverage Determinations developed by contractors.

TREATMENT DAY means a single calendar day on which treatment, evaluation and/or reevaluation 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, Home Health and SNF Services - A Brief Description
      10.2 - 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 - Outpatient Defined
      20.4.1 - Diagnostic Services Defined
      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 for Extended Care Services
      50.3 - Physical Therapy, Speech-Language Pathology, 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

    - Ch 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage

      10 - Comprehensive Outpatient Rehabilitation Facility (CORF) Services Provided by Medicare
      20 - Required and Optional CORF Services
      20.1 - Required Services
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      30 - Rules for Provision of Services
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      40 - Specific CORF Services
      40.1 - Physicians' Services
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- 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
  160.7 - Electrical Nerve Stimulators
  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 - Mobility Assisted Equipment (MAE)
  280.4 - Seat Lift
  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 - Linking LCD and NCD ID Numbers to Edits

  - Chapter 13 - Local Coverage Determinations

    13.5.1 - Reasonable and Necessary Provisions in LCDs

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. 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.

When therapy services may be furnished appropriately in a community pool by a clinician in a physical therapist or occupational therapist private practice, physician office, outpatient hospital, or outpatient SNF, the practice/office or provider shall rent or lease the pool, or a specific portion of the pool. The use of that part of the pool during specified times shall be restricted to the patients of that practice or provider. The written agreement to rent or lease the pool shall be available for review on request. When part of the pool is rented or leased, the agreement shall describe the part of the pool that is used exclusively by the patients of that practice/office or provider and the times that exclusive use applies. Other providers, including rehabilitation agencies (previously referred to as OPTs and ORFs) and CORFs, are subject to the requirements outlined in the respective State Operations Manual regarding rented or leased community pools.

220.3 - Documentation Requirements for Therapy Services

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

A. General

To be payable, the medical record and the information on the claim form must consistently and accurately report covered therapy services, as documented in the medical record. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to Medicare requirements. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all 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 or professional guidelines of the relevant profession, the practice, or the facility may be more stringent. 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 (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due.

- Progress Reports (including Discharge Notes, if applicable) 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);

- 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 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 preparing records, clinicians must be familiar with the requirements for covered and payable outpatient therapy services. 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, and correspondence.

- 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.

- 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. Changes in objective and sometimes to subjective measures of improvement also help establish the need for rehabilitative 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 rehabilitative therapy or the patient's need for maintenance therapy.

- Functional information included on claims as required.

  The clinician is required to document in the patient's medical record, using the G-codes and severity modifiers used in functional reporting, the patient's current, projected goal, and discharge status, as reported pursuant to functional reporting requirements for each date of service for which the reporting is required. See section 220.4 below for details on documenting G-code and modifiers.

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 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 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, unrelated 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, 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. The day beginning 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 or the

10th treatment day, 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.

It should be emphasized that the dates for recertification of plans of care do not affect the dates for required progress reports. (Consideration of the case in preparation for a report may lead the therapist to request early recertification. However, each report does not require recertification of the plan, and there may be several reports between recertifications). In many settings, weekly progress reports are voluntarily prepared to review progress, describe the skilled treatment, update goals, and inform physician/NPPs or other staff. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary.

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 progress report period. 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 after 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 when one is indicated. Although the progress report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the revised plan

of care accompanied by the progress report shall be re-certified by a physician/NPP. See section 220.1.2C, Changes to the Therapy Plan, for guidance on when a revised plan requires certification.

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 (or Discharge Summary) is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. 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. PTAs or OTAs 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 clinicians 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 co-signatures 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.

<u>Content of Clinician (Therapist, Physician/NPP) Progress Reports.</u> 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.

- Functional documentation is required as part of the progress report at the end of each progress reporting period. It is also required at the time of discharge on the discharge note or summary, as applicable. The clinician documents, on the applicable dates of service, the specific nonpayable G-codes and severity modifiers used in the required reporting of the patient's functional limitation(s) on the claim for services, including how

the modifier selection was made. See subsection C of 220.4 below for details relevant to documentation requirements.

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:

- In the case of rehabilitative therapy, 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.

- In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.

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 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 phone consultation with 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. Since a clinician must be identified on the plan of care and the progress report, the name and professional identification of the supervisor responsible for the treatment is assumed to be the clinician who wrote the plan or 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 the responsible supervisor is absent, the presence of a similarly qualified supervisor on the clinic roster for that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation.

If a treatment is added or changed under the direction of a clinician during the treatment days between the 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 Pub. 100-04, Medicare Claims Processing Manual, 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.

280.1 – Glaucoma Screening

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

A. Conditions of Coverage

The regulations implementing the Benefits Improvements and Protection Act of 2000, §102, provide for annual coverage for glaucoma screening for beneficiaries in the following high risk categories:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma; or
- African-Americans age 50 and over.

In addition, beginning with dates of service on or after January 1, 2006, 42 CFR 410.23(a)(2), revised, the definition of an eligible beneficiary in a high-risk category is expanded to include:

- Hispanic-Americans age 65 and over.

Medicare will pay for glaucoma screening examinations where they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist, who is legally authorized to perform the services under State law.

Screening for glaucoma is defined to include:

- A dilated eye examination with an intraocular pressure measurement; and
- A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.

Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed.

The following HCPCS codes apply for glaucoma screening:

G0117 - Glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist; and

G0118 - Glaucoma screening for high-risk patients furnished under the direct supervision of an optometrist or ophthalmologist.

The type of service for the above G codes is: TOS Q.

For providers who bill *A/B MACs*, applicable types of bill for screening glaucoma services are 13X, 22X, 23X, 71X, 73X, 75X, and 85X. The following revenue codes should be reported when billing for screening glaucoma services:

- Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), skilled nursing facilities (SNFs), independent and provider-based RHCs and free standing and provider-based FQHCs bill for this service under revenue code 770. CAHs electing the optional method of payment for outpatient services report this service under revenue codes 96X, 97X, or 98X.

- Hospital outpatient departments bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 770.

- **Calculating the Frequency**

- Once a beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11-month period, start the count beginning with the month after the month in which the previous covered screening procedure was performed.

- **Diagnosis Coding Requirements**

- Providers bill glaucoma screening using *diagnosis codes for screening services*. Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable.

- **Payment Methodology**

- ***A/B MACs (B)***

- Contractors pay for glaucoma screening based on the Medicare physician fee schedule. Deductible and coinsurance apply. Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge (refer to the Medicare Claims Processing Manual, Chapter 12, "Physician/Non-physician Practitioners," for more information about the Medicare limiting charge).

- ***A/B MACs (A)***

- Payment is made for the facility expense as follows:

- Independent and provider-based RHC/free standing and provider-based FQHC - payment is made under the all inclusive rate for the screening glaucoma service based on the visit furnished to the RHC/FQHC patient;

- CAH - payment is made on a reasonable cost basis unless the CAH has elected the optional method of payment for outpatient services in which case, procedures outlined in the Medicare Claims Processing Manual, Chapter 3, §30.1.1, should be followed;

- CORF - payment is made under the Medicare physician fee schedule;

- Hospital outpatient department - payment is made under outpatient prospective payment system (OPPS);

- Hospital inpatient Part B - payment is made under OPPS;

- SNF outpatient - payment is made under the Medicare physician fee schedule (MPFS); and

- SNF inpatient Part B - payment is made under MPFS.

Deductible and coinsurance apply.

E. Special Billing Instructions for RHCs and FQHCs

Screening glaucoma services are considered RHC/FQHC services. RHCs and FQHCs bill the contractor under bill type 71X or 73X along with revenue code 770 and HCPCS codes G0117 or G0118 and RHC/FQHC revenue code 520 or 521 to report the related visit. Reporting of revenue code 770 and HCPCS codes G0117 and G0118 in addition to revenue code 520 or 521 is required for this service in order for CWF to perform frequency editing.

Payment should not be made for a screening glaucoma service unless the claim also contains a visit code for the service. Therefore, the contractor installs an edit in its system to assure payment is not made for revenue code 770 unless the claim also contains a visit revenue code (520 or 521).

280.2.3 - Determining Whether or Not the Beneficiary is at High Risk for Developing Colorectal Cancer

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

A. Characteristics of the High Risk Individual

An individual at high risk for developing colorectal cancer has one or more of the following:

A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
A family history of familial adenomatous polyposis;
A family history of hereditary nonpolyposis colorectal cancer;
A personal history of colorectal cancer;
A personal history of adenomatous polyps;
Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

B. Partial List of ICD-9-CM Codes Indicating High Risk *(for Services before Implementation of ICD-10)*

Listed below are some examples of diagnoses that meet the high risk criteria for colorectal cancer. This is not an all-inclusive list. There may be more instances of conditions which may be coded and could be at the medical directors' discretion.

- **Personal History**
    - V10.05 - Personal history of malignant neoplasm of large intestine
    - V10.06 - Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
- **Chronic Digestive Disease Condition**
    - 555.0 - Regional enteritis of small intestine
    - 555.1 - Regional enteritis of large intestine
    - 555.2 - Regional enteritis of small intestine with large intestine
    - 555.9 - Regional enteritis of unspecified site
    - 556.0 - Ulcerative (chronic) enterocolitis
    - 556.1 - Ulcerative (chronic) ileocolitis
    - 556.2 - Ulcerative (chronic) proctitis
    - 556.3 - Ulcerative (chronic) proctosigmoiditis
    - 556.8 - Other ulcerative colitis

- 556.9 - Ulcerative colitis, unspecified (nonspecific PDX on the MCE)

- **Inflammatory Bowel**

  - 558.2 - Toxic gastroenteritis and colitis
  - 558.9 - Other and unspecified noninfectious gastroenteritis and colitis

C. Partial List of ICD-10-CM Codes Indicating High Risk (for Services after Implementation of ICD-10)

Code	*Description*
K50.00	*Crohn's disease of small intestine without complications*
K50.011	*Crohn's disease of small intestine with rectal bleeding*
K50.012	*Crohn's disease of small intestine with intestinal obstruction*
K50.013	*Crohn's disease of small intestine with fistula*
K50.014	*Crohn's disease of small intestine with abscess*
K50.018	*Crohn's disease of small intestine with other complication*
K50.019	*Crohn's disease of small intestine with unspecified complications*
K50.10	*Crohn's disease of large intestine without complications*
K50.111	*Crohn's disease of large intestine with rectal bleeding*
K50.112	*Crohn's disease of large intestine with intestinal obstruction*
K50.113	*Crohn's disease of large intestine with fistula*
K50.114	*Crohn's disease of large intestine with abscess*
K50.118	*Crohn's disease of large intestine with other complication*
K50.119	*Crohn's disease of large intestine with unspecified complications*
K50.80	*Crohn's disease of both small and large intestine without complications*
K50.811	*Crohn's disease of both small and large intestine with rectal bleeding*
K50.812	*Crohn's disease of both small and large intestine with intestinal obstruction*
K50.813	*Crohn's disease of both small and large intestine with fistula*
K50.814	*Crohn's disease of both small and large intestine with abscess*
K50.818	*Crohn's disease of both small and large intestine with other complication*
K50.819	*Crohn's disease of both small and large intestine with unspecified complications*
K50.90	*Crohn's disease, unspecified, without complications*
K50.911	*Crohn's disease, unspecified, with rectal bleeding*
K50.912	*Crohn's disease, unspecified, with intestinal obstruction*
K50.913	*Crohn's disease, unspecified, with fistula*
K50.914	*Crohn's disease, unspecified, with abscess*

Code	Description
K50.918	Crohn's disease, unspecified, with other complication
K50.919	Crohn's disease, unspecified, with unspecified complications
K51.80	Other ulcerative colitis without complications
K51.80	Other ulcerative colitis without complications
K51.20	Ulcerative (chronic) proctitis without complications
K51.211	Ulcerative (chronic) proctitis with rectal bleeding
K51.212	Ulcerative (chronic) proctitis with intestinal obstruction
K51.213	Ulcerative (chronic) proctitis with fistula
K51.214	Ulcerative (chronic) proctitis with abscess
K51.218	Ulcerative (chronic) proctitis with other complication
K51.219	Ulcerative (chronic) proctitis with unspecified complications
K51.30	Ulcerative (chronic) rectosigmoiditis without complications
K51.311	Ulcerative (chronic) rectosigmoiditis with rectal bleeding
K51.312	Ulcerative (chronic) rectosigmoiditis with intestinal obstruction
K51.313	Ulcerative (chronic) rectosigmoiditis with fistula
K51.314	Ulcerative (chronic) rectosigmoiditis with abscess
K51.318	Ulcerative (chronic) rectosigmoiditis with other complication
K51.319	Ulcerative (chronic) rectosigmoiditis with unspecified complications
K51.80	Other ulcerative colitis without complications
K51.811	Other ulcerative colitis with rectal bleeding
K51.812	Other ulcerative colitis with intestinal obstruction
K51.813	Other ulcerative colitis with fistula
K51.814	Other ulcerative colitis with abscess
K51.818	Other ulcerative colitis with other complication
K51.819	Other ulcerative colitis with unspecified complications
K51.90	Ulcerative colitis, unspecified, without complications
K51.911	Ulcerative colitis, unspecified with rectal bleeding
K51.912	Ulcerative colitis, unspecified with intestinal obstruction
K51.913	Ulcerative colitis, unspecified with fistula
K51.914	Ulcerative colitis, unspecified with abscess
K51.918	Ulcerative colitis, unspecified with other complication

Code	Description
K51.919	Ulcerative colitis, unspecified with unspecified complications
K52.1	Toxic gastroenteritis and colitis
K52.89	Other specified noninfective gastroenteritis and colitis
K52.9	Noninfective gastroenteritis and colitis, unspecified
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
D12.6	Benign neoplasm of colon, unspecified
Z12.11	Encounter for screening for malignant neoplasm of colon
Z12.12	Encounter for screening for malignant neoplasm of rectum
Z15.09	Genetic susceptibility to other malignant neoplasm
Z80.0	Family history of malignant neoplasm of digestive organs
Z83.71	Family history of colonic polyps

280.4 - Screening Pap Smears

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

Effective, January 1, 1998, §4102 of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33) amended §1861(nn) of the Act (42 USC 1395X(nn)) to include coverage every *3* years for a screening Pap smear or more frequent coverage for women:

1. At high risk for cervical or vaginal cancer; or

2. Of childbearing age who have had a Pap smear during any of the preceding *3* years indicating the presence of cervical or vaginal cancer or other abnormality.

Effective July 1, 2001, the Consolidated Appropriations Act of 2001 (P.L. 106-554) modifies §1861(nn) to provide Medicare coverage for biennial screening Pap smears. Specifications for frequency limitations are defined below.

For claims with dates of service from January 1, 1998, through June 30, 2001, screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act), or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under one of the following conditions.

The beneficiary has not had a screening Pap smear test during the preceding *3* years (i.e., 35 months have passed following the month that the woman had the last covered Pap smear – ICD-9-CM code V76.2 *or ICD-10 code Z112.4* is used to indicate special screening for malignant neoplasm, cervix); or

There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any

of the preceding *3* years; and at least 11 months have passed following the month that the last covered Pap smear was performed; or

She is at high risk of developing cervical or vaginal cancer – ICD-9-CM code V15.89, other specified personal history presenting hazards to health) *or as applicable, ICD-10 code Z77.21, Z77.22, Z77.9, Z91.89, OR Z92.89* and at least 11 months have passed following the month that the last covered screening Pap smear was performed. The high risk factors for cervical and vaginal cancer are:

Cervical Cancer High Risk Factors

Early onset of sexual activity (under 16 years of age);

Multiple sexual partners (five or more in a lifetime);

History of a sexually transmitted disease (including HIV infection); and

Fewer than three negative or any Pap smears within the previous *7* years.

Vaginal Cancer High Risk Factors

The DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy.

The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening Pap smear for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening Pap smear covered by Medicare was performed.

B. For Claims with Dates of Service on or After July 1, 2001

When the beneficiary does not qualify for a more frequently performed screening Pap smear as noted in items 1 and 2 above, contractors pay for the screening Pap smear only after at least 23 months have passed following the month during which the beneficiary received her last covered screening Pap smear. All other coverage and payment requirements remain the same.

See the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services," for billing procedures.

310.3 - Limitations for Coverage

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

Medicare Part B covers KDE services:

- Up to six (6) sessions as a beneficiary lifetime maximum. A session is 1 hour. In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than 1 hour still constitutes 1 session.

- On an individual basis or in group settings; if the services are provided in a group setting, a group consists of 2 to 20 individuals who need not all be Medicare beneficiaries**.**

NOTE: Two HCPCS codes were created for this benefit and one or the other must be present, along with the appropriate *ICD diagnosis codes.*

The diagnosis codes are:

- *ICD-9-CM -* code 585.4 (chronic kidney disease, Stage IV (severe)), *or*
- *ICD-10-CM - code N18.4 (chronic kidney disease, Stage IV).*

The HCPCS codes are:

- G0420: Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour
- G0421: Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour