

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 88	Date: May 7, 2008
	Change Request 5921

SUBJECT: Therapy Personnel Qualifications and Policies Effective January 1, 2008

I. SUMMARY OF CHANGES: This CR provides guidance on the new regulations discussed in the Federal Register on November 27, 2007, concerning outpatient therapy services including personnel qualifications and the timing of recertification of plans of care. It addresses issues that arose during the comment period.

New / Revised Material

Effective Date: January 1, 2008

Implementation Date: June 9, 2008

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	15/220/Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
R	15/220.1.2/Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
R	15/220.1.3/Certification and Recertification of Need for Treatment and Therapy Plans of Care
R	15/220.3/Documentation Requirements for Therapy Services
R	15/230.1/Practice of Physical Therapy
R	15/230.2/Practice of Occupational Therapy
R	15/230.3/Practice of Speech-Language Pathology
R	15/230.4/Services Furnished by a Physical or Occupational Therapist in Private Practice

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

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

SECTION B: 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5921.1	On or after January 1, 2008, contractors shall apply the personnel qualifications in 42CFR484.4 to all Medicare settings in which physical therapy, occupational therapy or speech-language pathology services are provided except as described in 5921.2 and 5921.3.	X		X	X	X					
5921.2	On or after July 1, 2008, contractors shall apply the personnel qualifications in 42CFR484.4 to inpatient hospital services and inpatient critical access hospital services as required in 42CFR409.17	X		X	X	X					
5921.3	On or after July 1, 2008, contractors shall apply the personnel qualifications in 42CFR484.4 to posthospital SNF care as required in 42CFR409.23.	X		X	X	X					
5921.4	Contractors shall not require recertification of outpatient therapy plans of care every 30 calendar days during treatment.	X		X	X	X					
5921.5	Contractors shall require recertification of outpatient therapy plans of care in intervals not to exceed 90 calendar days after the initial treatment day.	X		X	X	X					
5921.6	Contractors shall require that the new or significantly modified (changed) plan of care for outpatient therapy services be certified within 30 calendar days after the initial therapy treatment under that plan.	X		X	X	X					
5921.7	Contractors shall not interpret the qualifications for speech-language pathologists to include a certificate of clinical competence in audiology.	X		X	X	X					
5921.8	Contractors shall require clinicians or facilities that appropriately furnish aquatic therapy in a community pool to rent or lease at least a portion of a pool for the exclusive use of the clinicians' or facilities patients.	X		X	X	X					
5921.9	Contractors shall not require a certification "statement" at the time of certification.	X		X	X	X					
5921.10	Contractors shall not deny services on the basis of a low frequency or duration of treatment.	X		X	X	X					
5921.11	Contractors shall interpret the certification interval as the longest duration described in the plan.	X		X	X	X					
5921.12	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5921.13	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X	X	X					

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5921.4	Note that the Progress Report Period has not changed. Progress reports are due at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The first day of the first reporting period is the same as the first day of the certification period and the first day of treatment (including evaluation). The first day of the second reporting period is the treatment day after the end of the first reporting period.
5921.5	Note that the policies continue to allow delayed certification of plans of care. Certifications are acceptable, even when late, if the services appear to have been provided under the care of any physician (not only the one who certifies). Appearance of the care of a physician may be in any form and includes orders, e.g., notes, phone conferences, team conferences and billing for physician services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.
5917.6	The guidance for delayed certification has not been changed. A new plan of care is either an initial plan of care or a plan of care that has been significantly modified or changed, resulting in a change in long term goals. It is expected that modifications to the plan concerning short term goals or treatment techniques will be made frequently and these changes do not require certification or recertification.
5921.7	Note that the paragraph concerning speech-language pathologist's services being billed by physical therapists has been removed from Pub. 100-02, chapter 15, section 230.2. Contractors are advised that legislation concerning enrollment of speech-language

X-Ref Requirement Number	Recommendations or other supporting information:
	pathologists is pending and that they should continue to pay for SLP services when provided by qualified SLPs in the same manner they are now, according to contractor discretion.
5921.8	The same policies, e.g., concerning safety and medical necessity, review of records, continue to apply to services provided in part of a pool as were applied when the policy required use of the entire pool.
5921.10	The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patient's goals. For example, better outcomes at less cost may sometimes be achieved by skilled treatment once or twice weekly to assess and modify the plan with independent exercise by the patient between skilled visits. Continued progress is a sign that treatment is effective and may indicate that skilled treatment should be continued.
5921.11	There is no restriction on the way duration of treatment or a certification interval may be expressed. Variations may include e.g., calendar days, number of treatment sessions, or number of weeks of treatment. Contractors shall interpret the certification interval using the longest of the durations in the plan. As long as the physician approves the plan and the plan does not extend more than 90 calendar days from the first treatment day of that plan, the certification is acceptable for either the number of treatments, the number of weeks, or the number of calendar days that represent the longest interpretation of the duration of treatment. For example, if a plan is written and certified for 3x/week x 4 weeks and the patient receives treatment 3/xweek for 3 weeks but is absent the 4 th week, then the planned 4 th week of treatment is still certified if it is delivered later, assuming the plan remains appropriate and the treatment remains skilled and necessary. Or, under the same circumstances the plan is still certified when it includes treatment 4 times the first week and 2 times the last week. A reasonable amount of variation in the plan is acceptable.

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Dorothy Shannon, 410-786-3396

Post-Implementation Contact(s): Medicare Contractors

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers and Regional Home Health Carriers (RHHs)*:

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

Section B: 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.

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

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

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-9 codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

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

The EPISODE of Outpatient Therapy – For the purposes of therapy policy, an outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under the care of the clinician (e.g., for evaluation or treatment) for the current condition(s) being treated by one therapy discipline (PT, or OT, or SLP) until the last date of service for that 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.

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.*

NONPHYSICIAN PRACTITIONERS (NPP) means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services.

PHYSICIAN with respect to outpatient rehabilitation therapy services means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine, or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

PATIENT, client, resident, and beneficiary are terms used interchangeably to indicate enrolled recipients of Medicare covered services.

PROVIDERS of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services. To qualify as providers of services, these providers must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made. Note that the word PROVIDER in sections 220 and 230 is not used to mean a person who provides a service, but is used as in the statute to mean a facility or agency such as rehabilitation agency or home health agency.

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified

therapist, within the scope of practice allowed by state law. Assistants are limited in the services they may provide (see section 230.1 and 230.2) and may not supervise others.

QUALIFIED PERSONNEL means staff (auxiliary personnel) who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP. See §230.5 of this manual. Qualified personnel may or may not be licensed as therapists but meet all of the requirements for therapists with the exception of licensure.

SIGNATURE means a legible identifier of any type *acceptable according to* policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.4.1.1 (B) 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. Speech-language pathologists are not suppliers because the Act does not provide coverage of any speech-language pathology services furnished by a speech-language pathologist as an independent practitioner. (See §230.3.)

THERAPIST refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, 230.2, and 230.3. Skills of a therapist are defined by the scope of practice for therapists in the state).

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

Therapy services referred to in this manual are those skilled rehabilitative services provided according to the standards and conditions in CMS manuals, (e.g., in this chapter and in 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.

Unless modified by the words “maintenance” or “not”, the term therapy refers to rehabilitative therapy services as described in §220.2(C).

TREATMENT DAY means a single calendar day on which treatment, evaluation 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,
 - o Chapter 1- General Overview
 - 10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice and SNF Services - A Brief Description
 - 10.2 - Posthospital Home Health Services
 - 10.3 - Supplementary Medical Insurance (Part B) - A Brief Description
 - 20.2 - Discrimination Prohibited
- Pub. 100-02, MEDICARE BENEFIT POLICY MANUAL

- o Ch 6 - Hospital Services Covered Under Part B
 - 10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals
 - 20 - Outpatient Hospital Services
 - 20.2 - Distinguishing Outpatient Hospital Services Provided Outside the Hospital
 - 20.4.1 - Coverage of Outpatient Therapeutic Services
 - 70 - Outpatient Hospital Psychiatric Services

- o Ch 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
 - 30.4. - Direct Skilled Rehabilitation Services to Patients
 - 40 - Physician Certification and Recertification
 - 50.3 - Physical, Speech, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements with the Facility and Under Its Supervision
 - 70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services

• Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL

- o 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

- o Part 2
 - 150.2 - Osteogenic Stimulator
 - 150.4 - Neuromuscular Electrical Stimulator (NMES) in the Treatment of Disuse Atrophy
 - 160.3 - Assessing Patient's Suitability for Electrical Nerve Stimulation
 - 160.7 - Electrical Nerve Stimulators
 - 160.11 - Osteogenic Stimulation
 - 160.12 - Neuromuscular Electrical Stimulation (NMES)
 - 160.13 - Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)
 - 160.17 - L-Dopa

- o 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

o Part 4

230.8 - Non-implantable Pelvic Flood Electrical Stimulator
240.7 - Postural Drainage Procedures and Pulmonary Exercises
270.1 -Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds
270.4 - Treatment of Decubitus Ulcers
280.3 - Specially Sized Wheelchairs
280.4 - Seat Lift
280.5 - Safety Roller
280.9 - Power Operated Vehicles That May Be Used as Wheelchairs
280.13 - Transcutaneous Electrical Nerve Stimulators (TENS)
290.1 - Home Health Visits to A Blind Diabetic

• Pub. 100-08 PROGRAM INTEGRITY MANUAL

o Chapter 3 - Verifying Potential Errors and Taking Corrective Actions
3.4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR 3.4.1.1.1 Exception From the Uniform Dollar Limitation (“Therapy Cap”)
o Chapter 13 - Local Coverage Determinations 13.5.1 - Reasonable and Necessary Provisions in LCDs Specific Therapy Policies. Sections 220 and 230 of this chapter describe the standards and conditions that apply generally to outpatient rehabilitation therapy services.

Specific policies may differ by setting. Other policies concerning therapy services are found in other manuals. When a therapy service policy is specific to a setting, it takes precedence over these general outpatient policies. For special rules on:

- CORFs - See chapter 12 of this manual and also Pub. 100-04, chapter 5;
- SNF - See chapter 8 of this manual and also Pub. 100-04, chapter 6, for SNF claims/billing;
- HHA - See chapter 7 of this manual, and Pub. 100-04, chapter 10;
- GROUP THERAPY AND STUDENTS - See Pub. 100-02, chapter 15, §230;
- ARRANGEMENTS - Pub. 100-01, chapter 5, §10.3;
- COVERAGE is described in the Medicare Program Integrity Manual, Pub. 100-08, chapter 13, §13.5.1; and
- THERAPY CAPS - See Pub. 100-04, chapter 5, §10.2, for a complete description of this financial limitation.

C. General

Therapy services are a covered benefit in §§1861(g), 1861(p), and 1861(ll) of the Act. Therapy services may also be provided incident to the services of a physician/NPP under §§1861(s)(2) and 1862(a)(20) of the Act.

Covered therapy services are furnished by providers, by others under arrangements with and under the supervision of providers, or furnished by suppliers (e.g., physicians, NPP, enrolled therapists), who meet the requirements in Medicare manuals for therapy services.

Where a prospective payment system (PPS) applies, therapy services are paid when services conform to the requirements of that PPS. For example, see Pub. 100-04 for a description of applicable Inpatient Hospital Part B and Outpatient PPS rules.

Reimbursement for therapy provided to Part A inpatients of hospitals or residents of SNFs in covered stays is included in the respective PPS rates.

Payment for therapy provided by an HHA under a plan of treatment is included in the home health PPS rate. Therapy may be billed by an HHA on bill type 34x if there are no home health services billed under a home health plan of care at the same time (e.g., the patient is not homebound), and there is a valid therapy plan of treatment.

In addition to the requirements described in this chapter, the services must be furnished in accordance with health and safety requirements set forth in regulations at 42CFR484, and 42CFR485.

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 providers of outpatient physical therapy and speech-language pathology (OPTs or rehabilitation agencies) and CORFs, are subject to the requirements outlined in the respective State Operations Manual regarding rented or leased community pools.

220.1.2 - Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

Reference: 42CFR 410.61

A. Establishing the plan (See §220.1.3 for certifying the plan.)

The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated).

The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the plan, which is described below, is not the same as certifying the plan, which is described in §§220.1.1 and 220.1.3

Outpatient therapy services shall be furnished under a plan established by:

- A physician/NPP (consultation with the treating physical therapist, occupational therapist, or speech-language pathologist is recommended. Only a physician may establish a plan of care in a CORF);
- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or
- The speech-language pathologist who will provide the speech-language pathology services.

The plan may be entered into the patient's therapy record either by the person who established the plan or by the provider's or supplier's staff when they make a written record of that person's oral orders before treatment is begun.

Treatment under a Plan. The evaluation and treatment may occur and are both billable either on the same day or at subsequent visits. It is appropriate that treatment begins when a plan is established.

Therapy may be initiated by qualified professionals or qualified personnel based on a dictated plan. Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same clinician who establishes the plan. Payment for services provided before a plan is established may be denied.

Two Plans. It is acceptable to treat under two separate plans of care when different physician's/NPP's refer a patient for different conditions. It is also acceptable to combine the plans of care into one plan covering both conditions if one or the other referring physician/NPP is willing to certify the plan for both conditions. The Treatment Notes continue to require timed code treatment minutes and total treatment time and need not be separated by plan. Progress Reports should be combined if it is possible to make clear that the goals for each plan are addressed. Separate Progress Reports referencing

each plan of care may also be written, at the discretion of the treating clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.

B. Contents of Plan (See §220.1.3 for certifying the plan.)

The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24 and 410.61) (See §220.3 for further documentation requirements):

- Diagnoses;
- Long term treatment goals; and
- Type, amount, duration and frequency of therapy services.

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. *The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.*

Long term treatment goals should be developed for the entire episode of care *in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. When episodes in the setting are short, measurable goals may not be achievable; documentation should state the clinical reasons progress cannot be shown.*

The type of treatment may be PT, OT, or SLP, or, where appropriate, the type may be a description of a specific treatment or intervention. (For example, where there is a single evaluation service, but the type is not specified, the type is assumed to be consistent with the therapy discipline (PT, OT, SLP) ordered, or of the therapist who provided the evaluation.) Where a physician/NPP establishes a plan, the plan must specify the type (PT, OT, SLP) of therapy planned.

There shall be different plans of care for each type of therapy discipline. When more than one discipline is treating a patient, each must establish a diagnosis, goals, etc. independently. However, the form of the plan and the number of plans incorporated into one document are not limited as long as the required information is present and related to each discipline separately. For example, a physical therapist may not provide services under an occupational therapist plan of care. However, both may be treating the patient for the same condition at different times in the same day for goals consistent with their own scope of practice.

The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed.

The frequency refers to the number of times in a week the type of treatment is provided. Where frequency is not specified, one treatment is assumed. If a scheduled holiday occurs on a treatment day that is part of the plan, it is appropriate to omit that treatment day unless the clinician who is responsible for writing Progress Reports determines that a brief, temporary pause in the delivery of therapy services would adversely affect the patient's condition.

The duration is the number of weeks, or the number of treatment sessions, for THIS PLAN of care. *If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.*

The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals. For example, it may be clinically appropriate, medically necessary, most efficient and effective to provide short term intensive treatment or longer term and less frequent treatment depending on the individuals' needs.

*It may be appropriate for therapists to taper the frequency of visits as the patient progresses toward an independent or caregiver assisted self management program with the intent of improving outcomes and limiting treatment time. For example, treatment may be provided 3 times a week for 2 weeks, then 2 times a week for the next 2 weeks, then once a week for the last 2 weeks. Depending on the individual's condition, such treatment may result in better outcomes, or may result in earlier discharge than routine treatment 3 times a week for 4 weeks. When tapered frequency is planned, the exact number of treatments per frequency level is not required to be projected in the plan, because the changes should be made based on assessment of daily progress. Instead, the beginning and end frequencies shall be planned. For example, amount, frequency and duration may be documented as "once daily, 3 times a week tapered to once a week over 6 weeks". Changes to the frequency may be made based on the clinicians clinical judgment and do not require recertification of the plan unless requested by the physician/NPP. The clinician should consider any comorbidities, tissue healing, the ability of the patient **and/or caregiver to do more independent self management** as treatment progresses, and any other factors related to frequency and duration of treatment.*

The above policy describes the minimum requirements for payment. It is anticipated that clinicians may choose to make their plans more specific, in accordance with good practice. For example, they may include these optional elements: short term goals, goals and duration for the current episode of care, specific treatment interventions, procedures, modalities or techniques and the amount of each. *Also, notations in the medical record of beginning date for the plan are recommended but not required to assist Medicare contractors in determining the dates of services for which the plan was effective.*

C. Changes to the Therapy Plan

Changes are made in writing in the patient's record and signed by one of the following professionals responsible for the patient's care:

- The physician/NPP;
- The physical therapist (in the case of physical therapy);
- The speech-language pathologist (in the case of speech-language pathology services);
- The occupational therapist (in the case of occupational therapy services; or
- The registered professional nurse or physician/NPP on the staff of the facility pursuant to the oral orders of the physician/NPP or therapist.

While the physician/NPP may change a plan of treatment established by the therapist providing such services, the therapist may not significantly alter a plan of treatment established or certified by a physician/NPP without their documented written or verbal approval [See §220.1.3(C)]. A change in long-term goals, (for example if a new condition was to be treated) would be a significant change. *Physician/NPP certification of the significantly modified plan of care shall be obtained within 30 days of the initial therapy treatment under the revised plan.* An insignificant alteration in the plan would be a *change* in the frequency or duration due to the patient's illness, or a modification of short-term goals to adjust for improvements made toward the same long-term goals. If a patient has achieved a goal and/or has had no response to a treatment that is part of the plan, the therapist may delete a specific intervention from the plan of care prior to physician/ NPP approval. This shall be reported to the physician/NPP responsible for the patient's treatment prior to the next certification.

Procedures (e.g., neuromuscular reeducation) and modalities (e.g., ultrasound) are not goals, but are the means by which long and short term goals are obtained. Changes to procedures and modalities do not require physician signature when they represent adjustments to the plan that result from a normal progression in the patient's disease or condition *or adjustments to the plan due to lack of expected response to the planned intervention, when the goals remain unchanged.* Only when the patient's condition changes significantly, making revision of long term goals necessary, is a physician's/NPP's signature required on the change, (long term goal changes may be accompanied by changes to procedures and modalities).

220.1.3 - Certification and Recertification of Need for Treatment and Therapy Plans of Care

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

Reference: 42CFR424.24(c)

See specific certification rules in Pub. [100-01, chapter 4, §20](#) for hospital services.

A. Method and Disposition of Certifications

Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. It is not appropriate for a physician/NPP to certify a plan of care if the patient was not under the care of some physician/NPP at the time of the treatment or if the patient did not need the treatment. Since delayed certification is allowed, the date the certification is signed is important only to determine if it is timely or delayed. The certification must relate to treatment during the *interval* on the claim. Unless there is reason to believe the plan was not signed appropriately, or it is not timely, no further evidence that the patient was under the care of a physician/NPP and that the patient needed the care is required.

The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility and/or practitioner. Acceptable documentation of certification may be, for example, a physician's progress note, a physician/NPP order, or a plan of care that is signed and dated by a physician/NPP, and indicates the physician/NPP is aware that therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan when there is evidence the plan was sent (e.g., to the office) or is available in the record (e.g., of the institution that employs the physician/NPP) for the physician/NPP to review. *For example, if during the course of treatment under a certified plan of care a physician sends an order for continued treatment for 2 more weeks, contractors shall accept the order as certification of continued treatment for 2 weeks under the same plan of care. If the new certification is for less treatment than previously planned and certified, this new certification takes the place of any previous certification. At the end of the 2 weeks of treatment (which might extend more than 2 calendar weeks from the date the order/certification was signed) another certification would be required if further treatment was documented as medically necessary.*

The certification should be retained in the clinical record and available if requested by the contractor.

B. Initial Certification of Plan

The physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements noted above in §220.1 for the *duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.*

Timing of Initial Certification. The provider or supplier (e.g., facility, physician/NPP, or therapist) should obtain certification as soon as possible after the plan of care is established, unless the requirements of delayed certification are met. "As soon as possible" means that the physician/NPP shall certify the *initial* plan as soon as it is obtained, or *within 30 days of* the initial therapy treatment. Since payment may be denied if a physician does not certify the plan, the therapist should forward the plan to the

physician as soon as it is established. Evidence of diligence in providing the plan to the physician may be considered by the *Medicare* contractor during review in the event of a delayed certification.

Timely certification of the *initial plan* is met when physician/NPP certification of the plan is documented, by signature or verbal order, and dated *in the 30 days following the first day of treatment (including evaluation)*. If the order to certify is verbal, it must be followed within 14 days by a signature to be timely. A dated notation of the order to certify the plan should be made in the patient's medical record.

Recertification is not required if the duration of the initially certified plan of care is more than the duration (length) of the entire episode of treatment.

C. Review of Plan and Recertification

Reference: 42CFR424.24(c), 1861(r), 42CFR 410.61(e).

The timing of recertification changed on January 1, 2008. Certifications signed on or after January 1, 2008, follow the rules in this section. Certifications signed on or prior to December 31, 2007, follow the rule in effect at that time, which required recertification every 30 calendar days.

Payment and coverage conditions require that the plan must be reviewed, *as often as necessary but at least whenever it is certified or recertified* to complete the certification requirements. It is not required that the same physician/NPP *who participated initially in recommending or planning the patient's care* certify and/or recertify the plans.

Recertifications that document the need for continued *or modified* therapy should be signed *whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initiation of treatment under that plan*, unless they are delayed.

Physician/NPP Options for Certification. A physician/NPP may certify or recertify a plan for *whatever duration of treatment* the physician/NPP determines is appropriate, *up to a maximum of 90 calendar days*. *Many episodes of therapy treatment last less than 30 calendar days. Therefore, it is expected that the physician/NPP should certify a plan that appropriately estimates the duration of care for the individual, even if it is less than 90 days. If the therapist writes a plan of care for a duration that is more or less than the duration approved by the physician/NPP, then the physician/NPP would document a change to the duration of the plan and certify it for the duration the physician/NPP finds appropriate (up to 90 days). Treatment beyond the duration certified by the physician/NPP requires that a plan be recertified for the extended duration of treatment. It is possible that patients will be discharged by the therapist before the end of the estimated treatment duration because some will improve faster than estimated and/or some were successfully progressed to an independent home program.*

Physicians/NPPs may require that the patient make a *physician/NPP* visit for an examination if, in the professional's judgment, the visit is needed prior to certifying the plan, *or during the planned treatment*. Physicians/NPPs should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care *that is certified*. *If the physician wishes to restrict the patient's treatment beyond a certain date when a visit is required, the physician should certify a plan only until the date of the visit. After that date, services will not be considered reasonable and necessary due to lack of a certified plan.* Physicians/NPPs should not sign a certification if they require a visit and a visit was not made. However, Medicare does not require a visit unless the National Coverage Determination (NCD) for a particular treatment requires it (e.g., see Pub. 100-03, §270.1 - Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds).

Restrictions on Certification. Certifications and recertifications by doctors of podiatric medicine must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable state law. Optometrists may order and certify only low vision services. Chiropractors may not certify or recertify plans of care for therapy services.

D. Delayed Certification

References: §1835(a) of the Act
42CFR424.11(d)(3)

Certifications are required for each *interval of treatment based on the patient's needs, not to exceed 90 calendar days from the initial therapy treatment. Certifications are timely when the initial certification (or certification of a significantly modified plan of care) is dated within 30 calendar days of the initial treatment under that plan. Recertification is timely when dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.* Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable without justification for 30 days after they are due. Delayed certification should include one or more certifications or recertifications on a single signed and dated document.

Delayed certifications should include any evidence the provider or supplier considers necessary to justify the delay. For example, a certification may be delayed because the physician did not sign it, or the original was lost. In the case of a long delayed certification (over 6 months), the provider or supplier may choose to submit with the delayed certification some other documentation (e.g., an order, progress notes, telephone contact, requests for certification or signed statement of a physician/NPP) indicating need for care and that the patient was under the care of a physician at the time of the treatment. Such documentation may be requested by the contractor for delayed certifications if it is required for review.

It is not intended that needed therapy be stopped or denied when certification is delayed. The delayed certification of otherwise covered services should be accepted unless the contractor has reason to believe that there was no physician involved in the patient's care, or treatment did not meet the patient's need (and therefore, the certification was signed inappropriately).

EXAMPLE: Payment should be denied if there is a certification signed 2 years after treatment by a physician/NPP who has/had no knowledge of the patient when the medical record also shows *e.g.*, no order, note, physician/NPP attended meeting, correspondence with a physician/NPP, documentation of discussion of the plan with a physician/NPP, documentation of sending the plan to any physician/NPP, or other indication that there was a physician/NPP involved in the case.

EXAMPLE: Payment should not be denied, even when certified 2 years after treatment, when there is evidence that a physician approved needed treatment, such as an order, documentation of therapist/physician/NPP discussion of the plan, chart notes, meeting notes, requests for certification, certifications for intervals before or after the service in question, or *physician/NPP services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.*

EXAMPLE: Subsequent certifications of plans for continued treatment for the same condition in the same patient may indicate physician certification of treatment that occurred between certification dates, even if the signature for one of the plans in the episode is delayed. If a certified plan of care ends March 30th and a new plan of care for continued treatment after March 30th is developed or signed by a therapist on April 15th and that plan is subsequently certified, that certification may be considered delayed and acceptable effective from the first treatment date after March 30th for the frequency and duration as described in the plan. Of course, documentation should continue to indicate that therapy during the delay is medically necessary, as it would for any treatment. The certification of the physician/NPP is interpreted as involvement and approval of the ongoing episode of treatment, including the treatment that preceded the date of the certification unless the physician/NPP indicates otherwise.

E. Denials Due to Certification

Denial for payment that is based on absence of certification is a technical denial, which means a statutory requirement has not been met. Certification is a statutory requirement in SSA 1835(a)(2)- ('periodic review' of the plan).

For example, if a patient is treated and the provider/supplier cannot produce (on contractor request) a plan of care (timely or delayed) for the billed treatment dates certified by a physician/NPP, then that service might be denied for lack of the required certification. If an appropriate certification is later produced, the denial shall be overturned.

In the case of a service furnished under a provider agreement as described in 42CFR489.21, the provider is precluded from charging the beneficiary for services denied as a result of missing certification.

However, if the service is provided by a supplier (in the office of the physician/NPP, or therapist) a technical denial due to absence of a certification results in beneficiary liability. For that reason, it is recommended that the patient be made aware of the need for certification and the consequences of its absence.

A technical denial decision may be reopened by the contractor or reversed on appeal as appropriate, if delayed certification is later produced.

220.3 - Documentation Requirements for Therapy Services

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

A. General

Therapy services shall be payable when the medical record and the information on the claim form consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to the requirements in Medicare manuals. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all legal/regulatory requirements applicable to Medicare claims.

The documentation guidelines in sections 220 and 230 of this chapter identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. State or local laws and policies, or the policies of the profession, the practice, or the facility may be more stringent. Additional documentation not required by Medicare is encouraged when it conforms to state or local law or to professional guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language Hearing Association. It is encouraged but not required that narratives that specifically justify the medical necessity of services be included in order to support approval when those services are reviewed. (See also section 220.2- Reasonable and Necessary Outpatient Rehabilitation Therapy Services)

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

B. Documentation Required

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

- Evaluation /and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;
- Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification (*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); and
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

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

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

Dates for Documentation. The date the documentation was made is important only to establish the date of the initial plan of care because therapy cannot begin until the plan is established unless treatment is performed or supervised by the same clinician who establishes the plan. However, contractors may require that treatment notes and progress reports be entered into the record within 1 week of the last date to which the Progress Report or Treatment Note refers. For example, if treatment began on the first of the month at a frequency of twice a week, a Progress Report would be required at the end of the month. Contractors may require that the Progress Report that describes that month of

treatment be dated not more than 1 week after the end of the month described in the report.

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

- The patient is under the care of a physician/NPP;

Physician/NPP care shall be documented by physician/NPP certification (approval) of the plan of care; and

Although not required, other evidence of physician/NPP involvement in the patient's care may include, for example: order/referral, conference, team meeting notes, *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.

A therapist's skill may also be required for safety reasons, if an unstable fracture requires the skill of a therapist to do an activity that might otherwise be done independently by the patient at home. Or the skill of a therapist might be required for a patient learning compensatory swallowing techniques to perform cervical auscultation and identify changes in voice and breathing that might signal aspiration. After the patient is judged safe for independent use of these compensatory techniques, the skill of a therapist is not required to feed the patient, or check what was consumed.

- Services are of appropriate type, frequency, intensity and duration for the individual needs of the patient.

Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.

Clinicians and contractors shall determine typical services using published professional literature and professional guidelines. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Services that exceed those typically billed should be carefully documented to justify their necessity, but are payable if the individual patient benefits from medically necessary services. Also, some services or episodes of treatment should be less than those typically billed, when the individual patient reaches goals sooner than is typical.

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

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

C. Evaluation/Re-Evaluation and Plan of Care

The initial evaluation, or the plan of care including an evaluation, should document the necessity for a course of therapy through objective findings and subjective patient self-reporting. Utilize the guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language and Hearing Association as guidelines, and not as policy. Only a clinician may perform an initial examination, evaluation, re-evaluation and assessment or establish a diagnosis or a plan of care. A clinician may include, as part of the evaluation or re-evaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others.

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

Evaluation shall include:

- A diagnosis (where allowed by state and local law) and description of the specific problem(s) to be evaluated and/or treated. The diagnosis should be specific and as relevant to the problem to be treated as possible. In many cases, both a medical diagnosis (obtained from a physician/NPP) and an impairment based treatment diagnosis related to treatment are relevant. The treatment diagnosis may or may not be identified by the therapist, depending on their scope of practice. Where a diagnosis is not allowed, use a condition description similar to the appropriate ICD-9 code. For example the medical diagnosis made by the physician is CVA; however, the treatment diagnosis or condition description for PT may be abnormality of gait, for OT, it may be hemiparesis, and for SLP, it may be dysphagia. For PT and OT, be sure to include the body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;

- **Results of one of the following four measurement instruments are recommended, but not required:**

National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association

Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO)

Activity Measure – Post Acute Care (AM-PAC)

OPTIMAL by Cedaron through the American Physical Therapy Association

- If results of one of the four instruments above is not recorded, the record shall contain instead the following information indicated by asterisks (*) and should contain (but is not required to contain) all of the following, as applicable. Since published research supports its impact on the need for treatment, information in the following indented bullets may also be included with the results of the above four instruments in the evaluation report at the clinician's discretion. This information may be incorporated into a test instrument or separately reported within the required documentation. If it changes, update this information in the re-evaluation, and/or Treatment Notes, and/or Progress Reports, and/or in a separate record. When it is provided, contractors shall take this documented information into account to determine whether services are reasonable and necessary.

Documentation supporting illness severity or complexity including, e.g.,

- Identification of other health services concurrently being provided for this condition (e.g., physician, PT, OT, SLP, chiropractic, nurse, respiratory therapy, social services, psychology, nutritional/dietetic services, radiation therapy, chemotherapy, etc.), and/ or
- Identification of durable medical equipment needed for this condition, and/or
- Identification of the number of medications the beneficiary is taking (and type if known); and/or
- If complicating factors (complexities) affect treatment, describe why or how. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but in some patients such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception to caps for necessary services. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient's condition as reported on a functional measurement tool may be so great as to suggest extended treatment is anticipated; and/or
- Generalized or multiple conditions. The beneficiary has, in addition to the primary condition being treated, another disease or condition being treated, or generalized musculoskeletal conditions, or conditions affecting multiple sites and these conditions will directly and significantly impact the rate of recovery; and/or.
- Mental or cognitive disorder. The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery; and/or.
- Identification of factors that impact severity including e.g., age, time since onset, cause of the condition, stability of symptoms, how typical/atypical are the symptoms of the diagnosed condition, availability of an intervention/treatment known to be effective, predictability of progress.

Documentation supporting medical care prior to the current episode, if any, (or document none) including, e.g.,

- Record of discharge from a Part A qualifying inpatient, SNF, or home health episode within 30 days of the onset of this outpatient therapy episode, or

- Identification of whether beneficiary was treated for this same condition previously by the same therapy discipline (regardless of where prior services were furnished; and
- Record of a previous episode of therapy treatment from the same or different therapy discipline in the past year.

Documentation required to indicate beneficiary health related to quality of life, specifically,

- The beneficiary's response to the following question of self-related health: "At the present time, would you say that your health is excellent, very good, fair, or poor?" If the beneficiary is unable to respond, indicate why; and

Documentation required to indicate beneficiary social support including, specifically,

- Where does the beneficiary live (or intend to live) at the conclusion of this outpatient therapy episode? (e.g., private home, private apartment, rented room, group home, board and care apartment, assisted living, SNF), and
- Who does beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode? (e.g., lives alone, spouse/significant other, child/children, other relative, 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 or at least once during each *30 calendar days*, whichever is less. 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, the 10th treatment day, or *the 30th calendar day of the episode of treatment*, 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. Particularly where the patient's medical status, or appropriate tapering of frequency due to expected progress towards goals, results in limited frequency e.g., (2-4 times a month), more frequent Progress Reports can differentiate rehabilitative from maintenance treatment, document progress and justify the continued necessity for skilled care.

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 7calendar 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 the section 220.1.2C on Plan of Care 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 Physical Therapist Assistants or Occupational Therapy Assistants may write elements of the Progress Report dated between clinician reports. Reports written by assistants are not complete Progress Reports. The clinician must write a Progress Report during each Progress Report Period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the 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 cosignatures on the report or in the clinician's Progress Report. (See section 220.1.2(C) to modify the plan for changes in long term goals).

The evaluation and plan of care are considered incorporated into the Progress Report, and information in them is not required to be repeated in the report. For example, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current Progress Report Period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

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

Content of Clinician (Therapist, Physician/NPP) Progress Reports. In addition to the requirements above for notes written by assistants, the Progress Report of a clinician shall also include:

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report; and
- Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.

A re-evaluation should not be required before every Progress Report routinely, but may be appropriate when assessment suggests changes not anticipated in the original plan of care.

Care must be taken to assure that documentation justifies the necessity of the services provided during the reporting period, particularly when reports are written at the minimum frequency. Justification for treatment must include, for example, objective evidence or a clinically supportable statement of expectation that:

- The patient's condition has the potential to improve or is improving in response to therapy;
- Maximum improvement is yet to be attained; and

- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.

Example: The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink thick liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks. Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia. Short Term Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials. Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%. The Progress Report for 1/3/06 to 1/29/06 states: 1. Improved to 80% of trials; 2. Achieved. Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions. New Goal: “5. Patient will implement above strategies to swallow a sip of water without coughing for 5 consecutive trials. Mary Johns, CCC-SLP, 1/29/06.” Note the provider is billing 92526 three times a week, consistent with the plan; progress is documented; skilled treatment is documented.

E. Treatment Note

The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim. Documentation is required for every treatment day, and every therapy service. The format shall not be dictated by contractors and may vary depending on the practice of the responsible clinician and/or the clinical setting.

The Treatment Note is not required to document the medical necessity or appropriateness of the ongoing therapy services. Descriptions of skilled interventions should be included in the plan or the Progress Reports and are allowed, but not required daily. Non-skilled interventions need not be recorded in the Treatment Notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff may be reported voluntarily as additional information if they are relevant and not billed. Specifics such as number of repetitions of an exercise and other details included in the plan of care need not be repeated in the Treatment Notes unless they are changed from the plan.

Documentation of each Treatment shall include the following required elements:

- Date of treatment; and

- Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and
- Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See 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, chapter 5, section 20.2 for instructions on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes.

230.1 - Practice of Physical Therapy

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

A. General

Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. (See Pub. 100-03, the Medicare National Coverage Determinations Manual, for specific conditions or services.) *For descriptions of aquatic therapy in a community center pool see section 220C of this chapter.*

B. Qualified Physical Therapist Defined

Reference: 42CFR484.4

The new personnel qualifications for physical therapists were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that a qualified physical therapist (PT) is a person who is licensed, if applicable, as a PT by the state in which he or she is practicing unless licensure does not apply, has graduated from an accredited PT education program and passed a national examination approved by the state in which PT services are provided. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services. The curriculum accreditation is provided by the Commission on Accreditation in Physical Therapy

Education (CAPTE) or, for those who graduated before CAPTE, curriculum approval was provided by the American Physical Therapy Association (APTA). For internationally educated PTs, curricula are approved by a credentials evaluation organization either approved by the APTA or identified in 8 CFR 212.15(e) as it relates to PTs. For example, in 2007, 8 CFR 212.15(e) approved the credentials evaluation provided by the Federation of State Boards of Physical Therapy (FSBPT) and the Foreign Credentialing Commission on Physical Therapy (FCCPT). The requirements above apply to all PTs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

Physical therapists whose current license was obtained on or prior to December 31, 2009, qualify to provide PT services to Medicare beneficiaries if they:

- graduated from a CAPTE approved program in PT on or before December 31, 2009 (examination is not required); or,*
- graduated on or before December 31, 2009, from a PT program outside the U.S. that is determined to be substantially equivalent to a U.S. program by a credentials evaluating organization approved by either the APTA or identified in 8 CFR 212.15(e) and also passed an examination for PTs approved by the state in which practicing.*

Or, PTs whose current license was obtained before January 1, 2008, may meet the requirements in place on that date (i.e., graduation from a curriculum approved by either the APTA, the Committee on Allied Health Education and Accreditation of the American Medical Association, or both).

Or, PTs meet the requirements who are currently licensed and were licensed or qualified as a PT on or before December 31, 1977, and had 2 years appropriate experience as a PT, and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Or, PTs meet the requirements if they are currently licensed and before January 1, 1966, they were:

- admitted to membership by the APTA; or*
- admitted to registration by the American Registry of Physical Therapists; or*
- graduated from a 4-year PT curriculum approved by a State Department of Education; or*
- licensed or registered and prior to January 1, 1970, they had 15 years of full-time experience in PT under the order and direction of attending and referring doctors of medicine or osteopathy.*

Or, PTs meet requirements if they are currently licensed and they were trained outside the U.S. before January 1, 2008, and after 1928 graduated from a PT curriculum approved in the country in which the curriculum was located, if that country had an organization that was a member of the World Confederation for Physical Therapy, and that PT qualified as a member of the organization.

For outpatient PT services that are provided incident to the services of physicians/NPPs, the requirement for PT licensure does not apply; all other personnel qualifications do apply. The qualified personnel providing PT services incident to the services of a physician/NPP must be trained in an accredited PT curriculum. For example, a person who, on or before December 31, 2009, graduated from a PT curriculum accredited by CAPTE, but who has not passed the national examination or obtained a license, could provide Medicare outpatient PT therapy services incident to the services of a physician/NPP if the physician assumes responsibility for the services according to the incident to policies. On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide PT services incident to the services of a physician/NPP.

C. Services of Physical Therapy Support Personnel

Reference: 42CFR 484.4

Personnel Qualifications. *The new personnel qualifications for physical therapist assistants (PTA) were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.*

The regulation provides that a qualified PTA is a person who is licensed as a PTA unless licensure does not apply, is registered or certified, if applicable, as a PTA by the state in which practicing, and graduated from an approved curriculum for PTAs, and passed a national examination for PTAs. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location or the entity billing for the services. Approval for the curriculum is provided by CAPTE or, if internationally or military trained PTAs apply, approval will be through a credentialing body for the curriculum for PTAs identified by either the American Physical Therapy Association or identified in 8 CFR 212.15(e). A national examination for PTAs is, for example the one furnished by the Federation of State Boards of Physical Therapy. These requirements above apply to all PTAs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

Those PTAs also qualify who, on or before December 31, 2009, are licensed, registered or certified as a PTA and met one of the two following requirements:

- 1. Is licensed or otherwise regulated in the state in which practicing; or*

2. In states that have no licensure or other regulations, or where licensure does not apply, PTAs have:

- o graduated on or before December 31, 2009, from a 2-year college-level program approved by the APTA or CAPTE; and*
- o effective January 1, 2010, those PTAs must have both graduated from a CAPTE approved curriculum and passed a national examination for PTAs; or*

PTAs may also qualify if they are licensed, registered or certified as a PTA, if applicable and meet requirements in effect before January 1, 2008, that is,

- they have graduated before January 1, 2008, from a 2 year college level program approved by the APTA; or*
- on or before December 31, 1977, they were licensed or qualified as a PTA and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.*

Services. The services of PTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising physical therapist. PTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws.

A physical therapist must supervise PTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details. For example, in clinics, rehabilitation agencies, and public health agencies, 42CFR485.713 indicates that when a PTA provides services, either on or off the organization's premises, those services are supervised by a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation.

The services of a PTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

The cost of supplies (e.g., theraband, hand putty, electrodes) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the physical therapist, and are, therefore, not separately billable. Separate coverage and billing provisions apply to items that meet the definition of brace in §130.

Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although an aide may help the therapist by

providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

D. Application of Medicare Guidelines to PT Services

This subsection will be used in the future to illustrate the application of the above guidelines to some of the physical therapy modalities and procedures utilized in the treatment of patients.

230.2 - Practice of Occupational Therapy

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

A. General

Occupational therapy services are those services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. (See Pub. 100-03, the Medicare National Coverage Determinations Manual, for specific conditions or services.)

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve:

The evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;

The selection and teaching of task-oriented therapeutic activities designed to restore physical function; e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns;

The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness; e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient;

The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function; e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image;

The teaching of compensatory technique to improve the level of independence in the activities of daily living, for example:

- o Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand;
- o Teaching an upper extremity amputee how to functionally utilize a prosthesis;
- o Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities as independently as possible; or
- o Teaching a patient with a hip fracture/hip replacement techniques of standing tolerance and balance to enable the patient to perform such functional activities as dressing and homemaking tasks.

The designing, fabricating, and fitting of orthotics and self-help devices; e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed independently; or

Vocational and prevocational assessment and training, subject to the limitations specified in item B below.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician/NPP a plan of treatment.

B. Qualified Occupational Therapist Defined

Reference: 42CFR484.4

The new personnel qualifications for occupational therapists (OT) were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that a qualified OT is an individual who is licensed, if licensure applies, or otherwise regulated, if applicable, as an OT by the state in which practicing, and graduated from an accredited education program for OTs, and is eligible to take or has passed the examination for OTs administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT). The phrase, "by the state in which practicing" includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services. The education program for U.S. trained OTs is accredited by the Accreditation Council for Occupational Therapy Education (ACOTE). The requirements

above apply to all OTs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

The OTs may also qualify if on or before December 31, 2009:

- they are licensed or otherwise regulated as an OT in the state in which practicing (regardless of the qualifications they met to obtain that licensure or regulation); or*
- when licensure or other regulation does not apply, OTs have graduated from an OT education program accredited by ACOTE and are eligible to take, or have successfully completed the NBCOT examination for OTs.*

Also, those OTs who met the Medicare requirements for OTs that were in 42CFR484.4 prior to January 1, 2008, qualify to provide OT services for Medicare beneficiaries if:

- on or before January 1, 2008, they graduated an OT program approved jointly by the American Medical Association and the AOTA, or*
- they are eligible for the National Registration Examination of AOTA or the National Board for Certification in OT.*

Also, they qualify who on or before December 31, 1977, had 2 years of appropriate experience as an occupational therapist, and had achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Those educated outside the U.S. may meet the same qualifications for domestic trained OTs. For example, they qualify if they were licensed or otherwise regulated by the state in which practicing on or before December 31, 2009. Or they are qualified if they:

- graduated from an OT education program accredited as substantially equivalent to a U.S. OT education program by ACOTE, the World Federation of Occupational Therapists, or a credentialing body approved by AOTA; and*
- passed the NBCOT examination for OT; and*
- Effective January 1, 2010, are licensed or otherwise regulated, if applicable as an OT by the state in which practicing.*

For outpatient OT services that are provided incident to the services of physicians/NPPs, the requirement for OT licensure does not apply; all other personnel qualifications do apply. The qualified personnel providing OT services incident to the services of a physician/NPP must be trained in an accredited OT curriculum. For example, a person who, on or before December 31, 2009, graduated from an OT curriculum accredited by ACOTE and is eligible to take or has successfully completed the entry-level certification

examination for OTs developed and administered by NBCOT, could provide Medicare outpatient OT services incident to the services of a physician/NPP if the physician assumes responsibility for the services according to the incident to policies. On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide OT services incident to the services of a physician/NPP.

C. Services of Occupational Therapy Support Personnel

Reference: 42CFR 484.4

The new personnel qualifications for occupational therapy assistants were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that an occupational therapy assistant is a person who is licensed, unless licensure does not apply, or otherwise regulated, if applicable, as an OTA by the state in which practicing, and graduated from an OTA education program accredited by ACOTE and is eligible to take or has successfully completed the NBCOT examination for OTAs. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services.

If the requirements above are not met, an OTA may qualify if, on or before December 31, 2009, the OTA is licensed or otherwise regulated as an OTA, if applicable, by the state in which practicing, or meets any qualifications defined by the state in which practicing.

Or, where licensure or other state regulation does not apply, OTAs may qualify if they have, on or before December 31, 2009:

- completed certification requirements to practice as an OTA established by a credentialing organization approved by AOTA; and*
- after January 1, 2010, they have also completed an education program accredited by ACOTE and passed the NBCOT examination for OTAs.*

OTAs who qualified under the policies in effect prior to January 1, 2008, continue to qualify to provide OT directed and supervised OTA services to Medicare beneficiaries. Therefore, OTAs qualify who after December 31, 1977, and on or before December 31, 2007:

- completed certification requirements to practice as an OTA established by a credentialing organization approved by AOTA; or*

- *completed the requirements to practice as an OTA applicable in the state in which practicing.*

Those OTAs who were educated outside the U.S. may meet the same requirements as domestically trained OTAs. Or, if educated outside the U.S. on or after January 1, 2008, they must have graduated from an OTA program accredited as substantially equivalent to OTA entry level education in the U.S. by ACOTE, its successor organization, or the World Federation of Occupational Therapists or a credentialing body approved by AOTA. In addition, they must have passed an exam for OTAs administered by NBCOT.

Services. The services of OTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising occupational therapist. OTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating occupational therapist and in accordance with state laws.

An occupational therapist must supervise OTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for OTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details. For example, in clinics, rehabilitation agencies, and public health agencies, 42CFR485.713 indicates that when an OTA provides services, either on or off the organization's premises, those services are supervised by a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation.

The services of an OTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

The cost of supplies (e.g., looms, ceramic tiles, or leather) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the occupational therapist and are, therefore, not separately billable. Separate coverage and billing provisions apply to items that meet the definition of brace in §130 of this manual.

Services provided by aides, even if under the supervision of a therapist, are not therapy services in the outpatient setting and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

D. Application of Medicare Guidelines to Occupational Therapy Services

Occupational therapy may be required for a patient with a specific diagnosed psychiatric illness. If such services are required, they are covered assuming the coverage criteria are

met. However, where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient. Patient motivation is an appropriate and inherent function of all health disciplines, which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist are not required, an occupational therapy program for individuals who do not have a specific diagnosed psychiatric illness is not to be considered reasonable and necessary for the treatment of an illness or injury. Services furnished under such a program are not covered.

Occupational therapy may include vocational and prevocational assessment and training. When services provided by an occupational therapist are related solely to specific employment opportunities, work skills, or work settings, they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are not covered. However, carriers and intermediaries exercise care in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and nonvocational purposes. For example, an assessment of sitting and standing tolerance might be nonvocational for a mother of young children or a retired individual living alone, but could also be a vocational test for a sales clerk. Training an amputee in the use of prosthesis for telephoning is necessary for everyday activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability. The techniques of adjustment cannot be considered exclusively vocational or nonvocational.

230.3 - Practice of Speech-Language Pathology

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

A. General

Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See Pub. 100-03, chapter 1, §170.3)

B. Qualified Speech-Language Pathologist Defined

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech-Language Hearing Association; or

- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.

C. Services of Speech-Language Pathology Support Personnel

Services of speech-language pathology assistants are not recognized for Medicare coverage. Services provided by speech-language pathology assistants, even if they are licensed to provide services in their states, will be considered unskilled services and denied as not reasonable and necessary if they are billed as therapy services.

Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

D. Application of Medicare Guidelines to Speech-Language Pathology Services

1. Evaluation Services

Speech-language pathology evaluation services are covered if they are reasonable and necessary and not excluded as routine screening by §1862(a)(7) of the Act. The speech-language pathologist employs a variety of formal and informal speech, language, and dysphagia assessment tests to ascertain the type, causal factor(s), and severity of the speech and language or swallowing disorders. Reevaluation of patients for whom speech, language and swallowing were previously contraindicated is covered only if the patient exhibits a change in medical condition. However, monthly reevaluations; e.g., a Western Aphasia Battery, for a patient undergoing a rehabilitative speech-language pathology program, are considered a part of the treatment session and shall not be covered as a separate evaluation for billing purposes. Although hearing screening by the speech-language pathologist may be part of an evaluation, it is not billable as a separate service.

2. Therapeutic Services

The following are examples of common medical disorders and resulting communication deficits, which may necessitate active rehabilitative therapy. This list is not all-inclusive:

Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;

Neurological disease such as Parkinsonism or Multiple Sclerosis with dysarthria, dysphagia, inadequate respiratory volume/control, or voice disorder; or

Laryngeal carcinoma requiring laryngectomy resulting in aphonia.

3. *Impairments of the Auditory System*

The terms, aural rehabilitation, auditory rehabilitation, auditory processing, lipreading and speech reading are among the terms used to describe covered services related to perception and comprehension of sound through the auditory system. See Pub. 100-04, chapter 12, section 30.3 for billing instructions. For example:

- *Auditory processing evaluation and treatment may be covered and medically necessary. Examples include but are not limited to services for certain neurological impairments or the absence of natural auditory stimulation that results in impaired ability to process sound. Certain auditory processing disorders require diagnostic audiological tests in addition to speech-language pathology evaluation and treatment.*
- *Evaluation and treatment for disorders of the auditory system may be covered and medically necessary, for example, when it has been determined by a speech-language pathologist in collaboration with an audiologist that the **hearing impaired** beneficiary's current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient's functional communication needs. *Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologists may provide treatment.**

Assessment for the need for rehabilitation *of the auditory system (but not the vestibular system)* may be done by a speech language pathologist. *Examples include but are not limited to:* evaluation of comprehension and production of language in oral, signed or written modalities, speech and voice production, listening skills, speech reading, communications strategies, and the impact of the hearing loss on the patient/client and family.

Examples of rehabilitation include but are not limited to treatment that focuses on comprehension, and production of language in oral, signed or written modalities; speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training, communication strategies, education and counseling. In determining the necessity for treatment, the beneficiary's performance in both clinical and natural environment should be considered.

4. Dysphagia

Dysphagia, or difficulty in swallowing, can cause food to enter the airway, resulting in coughing, choking, pulmonary problems, aspiration or inadequate nutrition and hydration with resultant weight loss, failure to thrive, pneumonia and death. It is most often due to complex neurological and/or structural impairments including head and neck trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, dementias, and encephalopathies. For these reasons, it is important that only qualified professionals with specific training and experience in this disorder provide evaluation and treatment.

The speech-language pathologist performs clinical and instrumental assessments and analyzes and integrates the diagnostic information to determine candidacy for intervention as well as appropriate compensations and rehabilitative therapy techniques. The equipment that is used in the examination may be fixed, mobile or portable. Professional guidelines recommend that the service be provided in a team setting with a physician/NPP who provides supervision of the radiological examination and interpretation of medical conditions revealed in it.

Swallowing assessment and rehabilitation are highly specialized services. The professional rendering care must have education, experience and demonstrated competencies. Competencies include but are not limited to: identifying abnormal upper aerodigestive tract structure and function; conducting an oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques.

230.4 - Services Furnished by a Physical or Occupational Therapist in Private Practice

(Rev. 88, Issued: 05-07-08, Effective: 01-01-08, Implementation: 06-09-08)

A. General

In order to qualify to bill Medicare directly as a therapist, each individual must be enrolled as a private practitioner and employed in one of the following practice types: an unincorporated solo practice, unincorporated partnership, unincorporated group practice, physician/NPP group or groups that are not professional corporations, if allowed by state and local law. Physician/NPP group practices may employ physical therapists in private practice (PTPP) and/or occupational therapists in private practice (OTPP) if state and local law permits this employee relationship.

For purposes of this provision, a physician/NPP group practice is defined as one or more physicians/NPPs enrolled with Medicare who may bill as one entity. For further details on issues concerning enrollment, see the provider enrollment Web site at www.cms.hhs.gov/providers/enrollment.

Private practice also includes therapists who are practicing therapy as employees of another supplier, of a professional corporation or other incorporated therapy practice.

Private practice does not include individuals when they are working as employees of an institutional provider.

Services should be furnished in the therapist's or group's office or in the patient's home. The office is defined as the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in the practice at that location. If services are furnished in a private practice office space, that space shall be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. *For descriptions of aquatic therapy in a community center pool see section 220C of this chapter.*

Therapists in private practice must be approved as meeting certain requirements, but do not execute a formal provider agreement with the Secretary.

If therapists who have their own Medicare Personal Identification number (PIN) or National Provider Identifier (NPI) are employed by therapist groups, physician/NPP groups, or groups that are not professional organizations, the requirement that therapy space be owned, leased, or rented may be satisfied by the group that employs the therapist. Each physical or occupational therapist employed by a group should enroll as a PT or OT in private practice.

When therapists with a Medicare PIN/NPI provide services in the physician's/NPP's office in which they are employed, and bill using their PIN/NPI for each therapy service, then the direct supervision requirement for PTAs and OTAs apply.

When the PT or OT who has a Medicare PIN/ NPI is employed in a physician's/NPP's office the services are ordinarily billed as services of the PT or OT, with the PT or OT identified on the claim as the supplier of services. However, services of the PT or OT who has a Medicare PIN/NPI may also be billed by the physician/NPP as services incident to the physician's/NPP's service. (See §230.5 for rules related to PTA and OTA services incident to a physician.) In that case, the physician/NPP is the supplier of service, the Unique Provider Identification Number (UPIN) or NPI of the physician/NPP (ordering or supervising, as indicated) is reported on the claim with the service and all the rules for incident to services (§230.5) must be followed.

B. Private Practice Defined

Reference: **Federal Register** November, 1998, pages 58863-58869; 42CFR 410.38(b)

The carrier considers a therapist to be in private practice if the therapist maintains office space at his or her own expense and furnishes services only in that space or the patient's home. Or, a therapist is employed by another supplier and furnishes services in facilities provided at the expense of that supplier.

The therapist need not be in full-time private practice but must be engaged in private practice on a regular basis; i.e., the therapist is recognized as a private practitioner and for that purpose has access to the necessary equipment to provide an adequate program of therapy.

The physical or occupational therapy services must be provided either by or under the direct supervision of the therapist in private practice. Each physical or occupational therapist in a practice should be enrolled as a Medicare provider. If a physical or occupational therapist is not enrolled, the services of that therapist must be directly supervised by an enrolled physical or occupational therapist. Direct supervision requires that the supervising private practice therapist be present in the office suite at the time the service is performed. These direct supervision requirements apply only in the private practice setting and only for physical therapists and occupational therapists and their assistants. In other outpatient settings, supervision rules differ. The services of support personnel must be included in the therapist's bill. The supporting personnel, including other therapists, must be W-2 or 1099 employees of the therapist in private practice or other qualified employer.

Coverage of outpatient physical therapy and occupational therapy under Part B includes the services of a qualified therapist in private practice when furnished in the therapist's office or the beneficiary's home. For this purpose, "home" includes an institution that is used as a home, but not a hospital, CAH or SNF, (**Federal Register** Nov. 2, 1998, pg 58869). Place of Service (POS) includes:

- 03/School, only if residential,
- 04/Homeless Shelter,
- 12/Home, other than a facility that is a private residence,
- 14/Group Home,
- 33/Custodial Care Facility.

C. Assignment

Reference: Nov. 2, 1998 **Federal Register**, pg. 58863

See also Pub. 100-04 chapter 1, §30.2.

When physicians, NPPs, PTPPs or OTPPs obtain provider numbers, they have the option of accepting assignment (participating) or not accepting assignment (nonparticipating). In contrast, providers, such as outpatient hospitals, SNFs, rehabilitation agencies, and CORFs, do not have the option. For these providers, assignment is mandatory.

If physicians/NPPs, PTPPs or OTPPs accept assignment (are participating), they must accept the Medicare Physician Fee Schedule amount as payment. Medicare pays 80% and the patient is responsible for 20%. In contrast, if they do not accept assignment, Medicare will only pay 95% of the fee schedule amount. However, when these services

are not furnished on an assignment-related basis, the limiting charge applies. (See §1848(g)(2)(c) of the Act.)

NOTE: Services furnished by a therapist in the therapist's office under arrangements with hospitals in rural communities and public health agencies (or services provided in the beneficiary's home under arrangements with a provider of outpatient physical or occupational therapy services) are not covered under this provision. See section 230.6.