

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 255	Date: January 25, 2019
	Change Request 11120

SUBJECT: Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make updates to Publications 100-02 and 100-04 to reflect recent changes in outpatient therapy service billing instructions and payment policies related to the Bipartisan Budget Act of 2018 and the calendar year 2019 Medicare physician fee schedule final rule.

EFFECTIVE DATE: January 1, 2019

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

IMPLEMENTATION DATE: February 26, 2019

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/revise 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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/20.1/Required Services
R	12/30/Rules for Provision of Services
R	12/30.1/Rules for Payment of CORF Services
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/Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
R	15/220.1.2/Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
R	15/220.2/Reasonable and Necessary Outpatient Rehabilitation Therapy Services
R	15/220.3/Documentation Requirements for Therapy Services
R	15/220.4/Functional Reporting

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 255	Date: January 25 2019	Change Request: 11120
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SUBJECT: Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018

EFFECTIVE DATE: January 1, 2019

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I. GENERAL INFORMATION

A. Background: Section 50202 of the Bipartisan Budget Act of 2018 repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold of incurred expenses above which claims must include a modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record.

In the Calendar Year (CY) 2019 Physician Fee Schedule final rule, after a consideration of stakeholders' requests for burden reduction and a review of the Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJA) requirements, CMS concluded that continued collection of functional reporting data through the same format would not yield additional information to inform future analyses. The rule ended the functional reporting requirements to reduce burden of reporting for providers of therapy services.

This change request updates the Medicare Benefit Policy Manual to reflect these changes to law and regulation.

B. Policy: Effective for dates of service on or after January 1, 2018, providers of therapy services shall continue to report the KX modifier on claims as applicable. The modifier no longer represents an exception request but serves as a confirmation that services are medically necessary after the beneficiary has exceeded the threshold of incurred expenses.

Effective for dates of service on or after January 1, 2019, Healthcare Common Procedure Coding System (HCPCS) G-codes and severity modifiers for functional reporting are no longer required on claims for therapy services.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11120 - 02.1	The contractor shall be aware of the changes to Pub.100-02, chapters 12 and 15 contained in this CR.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11120 - 02.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov (for institutional claims) , Brian Reitz, brian.reitz@cms.hhs.gov (for professional claims) , Pam West, pamela.west@cms.hhs.gov (for therapy payment policy)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Benefit Policy Manual

Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage

20.1 - Required Services

(Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

Section 1861(cc) of the Act defines a CORF as a facility that is primarily engaged in providing outpatient rehabilitation to the injured and disabled or to patients recovering from illness. The CORF must provide the following core CORF services: a) CORF physicians' services, b) physical therapy services, and c) social and/or psychological services. Physical therapy services should comprise a clear majority of the total CORF services provided when the CORF offers the three core CORF services. A physician must certify, as a condition of payment, that all CORF services are required because the individual needs skilled rehabilitation services. Skilled rehabilitation services are defined as services requiring the skills of physical therapists, speech-language pathologists or occupational therapists. In addition, respiratory therapists are recognized to provide skilled respiratory therapy services only under the CORF benefit.

A CORF is recognized as a provider of rehabilitation services. It is paid under the physician fee schedule for all CORF services and items except for CORF physician services (which are administrative in nature), drugs and biologicals and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). To participate in Medicare, a CORF must furnish at least the following:

- CORF physicians' services - includes professional services performed by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs services. These services are administrative in nature, such as consultation with, and medical supervision of, CORF qualified personnel, patient case review conferences, utilization review, and review of the rehabilitation plan of treatment, as appropriate. The physician must ensure that CORF services are provided in accordance with accepted principles of medical practice, medical direction and medical supervision. Subsequent to completing a 1-year hospital internship, the physician must have completed at least 1-year of training in the medical management of patients requiring rehabilitative services (42CFR485.70) or at least 1 year of full-time or part-time experience in a rehabilitation setting providing physician services similar to those required in a rehabilitation facility. A physician who specializes only in pulmonary rehabilitation does not meet these requirements as he/she is not likely to have the experience needed to medically manage patients that need physical therapy, occupational therapy and speech-language pathology services. Diagnostic or therapeutic services provided to a CORF patient by the CORF physician or other physician are not CORF physician services. Such services are separately payable to the physician and not the CORF under the physician fee schedule at the non-facility payment amount. These services should be billed as if they were provided in the physician's office. (See 42CFR410.100(a) and section 40.1.)
- Physical therapy services - include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached (See 42CFR410.100(b) and section 40.2); and
- Social and/or psychological services – are covered only if the patient's physician or the CORF physician establishes that the services directly relate to the patient's rehabilitation plan of treatment and are needed to achieve the goals in the rehabilitation plan of treatment. Social and/or psychological services include only those services that address the patient's response and adjustment to the rehabilitation treatment plan; rate of improvement and progress towards the rehabilitation

goals, or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment being provided to the patient. CORF social and/or psychological services do not include services for mental health diagnoses (See 42CFR410.100(h) and section 40.7.)

To receive Medicare payment for covered services, the CORF must have adequate space and equipment necessary for any of the services provided. Additionally, in order to accept a patient, the CORF must be able to provide all of the services required by the patient, as established in the rehabilitation plan of treatment. If the CORF does not have the necessary qualified personnel to provide the service(s), it must arrange for the service(s) to be provided at the CORF, as needed.

Functional reporting is required on claims for CORF physical therapy, occupational therapy, and speech-language pathology services by section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012. (See 42CFR410.105 and 42CFR410.59, 60, and 62.) **NOTE: Functional reporting and its associated documentation requirements are no longer applicable for claims or medical records for dates of service on and after January 1, 2019. See the NOTE at the beginning of subsection F in Section 30 below for more information.**

The CORF services are subject to the Medicare Part B deductible and coinsurance provisions. The CORF may bill the beneficiary only for the unmet portion of the deductible and 20 percent of the fee schedule amount for covered services.

30 - Rules for Provision of Services

(Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

A. Place of Treatment

In general, CORF services, except for physical therapy, occupational therapy, speech-language pathology services, and the single home environment evaluation, must be furnished on the premises of the CORF. Physical therapy, occupational therapy, and speech-language pathology services provided in the home are not covered as CORF services if payment for such services is made under the Medicare home health benefit. Although, physical therapy, occupational therapy, and speech-language pathology services can be furnished in the patient's home, a majority of these services must be provided on the CORF premises for all CORF patients.

A single, home environment evaluation visit is a covered CORF service if it is included in the physical therapy, occupational therapy or speech-language pathology plan of treatment.

A CORF cannot provide items or services that are not included in the definition of CORF services at 42CFR410.100 other than vaccines (CY 2008 PFS Rule 72 FR 66293). Those services included in the definition of CORF services are covered only to the extent that they support or further the rehabilitation plan of treatment.

B. Personnel Qualification Requirements

Services must be furnished or supervised by qualified personnel in accordance with regulation 42CFR485.70. Payment for social and/or psychological services, nursing services and respiratory therapy services is made when provided as specified in sections 40.7, 40.8 and 40.5 respectively of this chapter, as appropriate.

Determinations regarding whether services are furnished in accordance with the conditions of participation and under the supervision of qualified personnel as noted at section 20.2 are primarily the responsibility of

the State survey agency responsible for survey and certification of the facility. If services are not being furnished or appropriately supervised by qualified personnel, the Medicare contractor will withhold payment until the matter is resolved, as appropriate.

C. Services Furnished Under Arrangements

Any CORF service defined in §§20 or 40 may be furnished under arrangement and must meet the requirements of Pub. 100-01 chapter 5, section 10.3.

D. Referral for Treatment

To become a patient of a CORF, the beneficiary must be under the care of a physician who certifies that the beneficiary needs skilled rehabilitation services.

The referring physician must advise the CORF of the beneficiary's medical history, current diagnosis and medical findings, desired rehabilitation goals, and any contraindications to specific activity or intensity of rehabilitation services. If the rehabilitation goals for physical therapy, occupational therapy, speech-language pathology or respiratory therapy services are not specified by the referring physician, the CORF physician must establish them.

E. Plan of Treatment

The CORF services must be furnished under a written rehabilitation plan of treatment established and signed by a physician who has recently evaluated the patient. It is expected that the physician will establish the rehabilitation plan of treatment in consultation with the physical therapist, occupational therapist or speech-language pathologist who will provide the actual therapy. The physician wholly establishes the respiratory therapy plan of treatment. The physician may be either a CORF physician or the patient's referring physician if the physician provides a detailed rehabilitation plan of treatment that meets the following requirements.

The rehabilitation plan of treatment must be established and signed by a physician prior to the commencement of treatment in the CORF setting and contain the diagnosis, the type, amount, frequency, and duration of skilled rehabilitation services to be performed, and the anticipated skilled rehabilitation goals. The services furnished under the rehabilitation plan of treatment must be reasonable and medically necessary and relate directly to the rehabilitation of injured, disabled, or sick patients. The skilled rehabilitation goals for physical therapy, occupational therapy, and speech-language pathology plans of treatment must be consistent with those used for the Functional reporting pursuant to 410.105(d). For related documentation requirements, see subsection F below. For more details on documentation requirements, refer to chapter 15, section 220.3, of this manual. ***NOTE: Functional reporting and documentation requirements are no longer applicable for claims for dates of service on and after January 1, 2019. For more information, refer to the NOTE in subsection F below.***

The CORF physician or the referring physician for physical therapy, occupational therapy and speech-language pathology services, must review the plan of treatment at least once every 90 days certifying that the patient needs or continues to need skilled rehabilitation services, the rehabilitation plan of treatment is being followed and that the patient is making progress in attaining the established rehabilitation goals. The 90-day period begins with the first day of rehabilitation therapy. For respiratory therapy services, the CORF physician or the patient's referring physician must review the rehabilitation plan of treatment at least every 60 days. The 60-day period begins with the first day of respiratory therapy treatment. (For survey and certification the plan of treatment review must meet the requirements at 42CFR 485.58(b)). When the patient has reached a point where no further progress is being made toward one or more of the rehabilitation goals, or the skills of a therapist are no longer required, Medicare coverage ends with respect to that aspect of the rehabilitation plan of treatment.

F. Functional Reporting and Documentation Requirements for Physical Therapy, Occupational Therapy, and Speech-language Pathology Services.

***NOTE:** In the calendar year (CY) 2019 Physician Fee Schedule (PFS) final rule, CMS-1693-F, after consideration of stakeholder comments for burden reduction, a review of all of the requirements under section 3005(g) of Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA), and in light of the statutory amendments to section 1833(g) of the Act, via section 50202 of Bipartisan Budget Act of 2018 to repeal the therapy caps, CMS concluded that continued collection of functional reporting data through the same or reduced format would not yield additional information to inform future analyses or to serve as a basis for reforms to the payment system for therapy services. To reduce the burden of reporting for providers of therapy services, the CY 2019 PFS final rule ended the requirements of reporting the functional limitation nonpayable HCPCS G-codes and severity modifiers on claims for therapy services and the associated documentation requirements in medical records, effective for dates of service on and after January 1, 2019. The rule also revised regulation text at 42 CFR 410.59, 410.60, 410.61, 410.62, 410.105, accordingly.*

The instructions below apply only to dates of service when the functional reporting requirements were effective, January 1, 2013 through December 31, 2018.

Functional reporting is required on claims for CORF physical therapy, occupational therapy, and speech-language pathology services by section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012. (See 42CFR410.105 and 42CFR410.59, 60, and 62.)

The regulations implementing Section 3005(g) of the MCTRJCA require that nonpayable G-codes and severity modifiers be used to report the functional status of CORF patients receiving physical therapy, occupational therapy, and speech-language pathology services. This functional reporting is required to be included on claims at the beginning of treatment/outset of therapy, at specified reporting intervals which are consistent with those for progress reporting, and at discharge from therapy. In addition, functional reporting is required when an evaluative procedure, including a re-evaluative one, is billed. The functional G-codes and severity modifiers used in reporting the patient's functional status shall be documented in each patient's medical record. Refer to chapter 15, section 220 of this manual for instructions on selecting and documenting these functional G-codes and severity modifiers in the patient's medical record.

For details about the functional reporting requirements for G-codes and severity modifiers on claims for therapy services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6.

30.1 – Rules for Payment of CORF Services

(Rev.)

The payment basis for CORF services is 80 percent of the lesser of: (1) the actual charge for the service or (2) the physician fee schedule amount for the service when the physician fee schedule establishes a payment amount for such service. Payment for CORF services under the physician fee schedule is made for physical therapy, occupational therapy, speech-language pathology and respiratory therapy services, as well as the nursing and social and/or psychological services, which are a part of, or directly relate to, the rehabilitation plan of treatment.

Payment for covered durable medical equipment, orthotic and prosthetic (DMEPOS) devices and supplies provided by a CORF is based upon: the lesser of 80 percent of actual charges or the payment amount established under the DMEPOS fee schedule; or, the single payment amount established under the DMEPOS competitive bidding program, provided that payment for such an item is not included in the payment amount for other CORF services.

If there is no fee schedule amount for a covered CORF item or service, payment should be based on the lesser of 80 percent of the actual charge for the service provided or an amount determined by the local Medicare contractor.

The following conditions apply to CORF physical therapy, occupational therapy, and speech-language pathology services;

- Claims must contain the required functional reporting. (Reference: Sections 42 CFR 410.105.) Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6. **NOTE:** *Functional reporting and documentation requirements are no longer applicable for claims for dates of service on and after January 1, 2019. For more information, refer to subsection F in section 30 above.*
- The functional reporting on claims must be consistent with the functional limitations identified as part of the patient's therapy plan of care and expressed as part of the patient's therapy goals; effective for claims with dates of service on and after January 1, 2013. (Reference: 42 CFR 410.105.) See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6. **NOTE:** *Functional reporting and documentation requirements are no longer applicable for claims for dates of service on and after January 1, 2019. For more information, refer to subsection F in section 30 above.*
- The National Provider Identifier (NPI) of the certifying physician identified for a CORF physical therapy, occupational therapy, and speech-language pathology plan of treatment must be included on the therapy claim. This requirement is effective for claims with dates of service on or after October 1, 2012. (See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.3.)

Payment for CORF social and/or psychological services is made under the physician fee schedule only for HCPCS code G0409, as appropriate, and only when billed using revenue codes 0560, 0569, 0910, 0911, 0914 and 0919.

Payment for CORF respiratory therapy services is made under the physician fee schedule when provided by a respiratory therapist as defined at 42CFR485.70(j) and, only to the extent that these services support or are an adjunct to the rehabilitation plan of treatment, when billed using revenue codes 0410, 0412 and 0419. Separate payment is not made for diagnostic tests or for services related to physiologic monitoring services which are bundled into other respiratory therapy services appropriately performed by a respiratory therapist, such as HCPCS codes G0237, G0238 and G0239.

Payment for CORF nursing services is made under the physician fee schedule only when provided by a registered nurse as defined at 42CFR485.70(h) for nursing services only to the extent that these services support or are an adjunct to the rehabilitation plan of treatment. In addition, payment for CORF nursing services is made only when provided by a registered nurse. HCPCS code G0128 is used to bill for these services and only with revenue codes 0550 and 0559.

For specific payment requirements for CORF items and services see Pub. 100-04, Medicare Claims Processing Manual, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services.

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

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

(Rev.255, Issued: 01-25-19, Effective: 01-01-19, Implementation: 02-26-19)

A comprehensive knowledge of the policies that apply to therapy services cannot be obtained through manuals alone. The most definitive policies are Local Coverage Determinations found at the Medicare Coverage Database www.cms.hhs.gov/mcd. A list of Medicare contractors is found at the CMS Web site. Specific questions about all Medicare policies should be addressed to the contractors through the contact information supplied on their Web sites. General Medicare questions may be addressed to the Medicare regional offices <http://www.cms.hhs.gov/RegionalOffices/>.

A. Definitions

The following defines terms used in this section and §230:

ACTIVE PARTICIPATION of the clinician in treatment means that the clinician personally furnishes in its entirety at least 1 billable service on at least 1 day of treatment.

ASSESSMENT is separate from evaluation, and is included in services or procedures, (it is not separately payable). The term assessment as used in Medicare manuals related to therapy services is distinguished from language in Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment, which may be payable). Assessments shall be provided only by clinicians, because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation (see definitions below) is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.

CERTIFICATION is the physician's/nonphysician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.

The **CLINICIAN** is a term used in this manual and in Pub 100-04, chapter 5, section 10 or section 20, to refer to only a physician, nonphysician practitioner or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law. Clinicians make clinical judgments and are responsible for all services they are permitted to supervise. Services that require the skills of a therapist, may be appropriately furnished by clinicians, that is, by or under the supervision of qualified physicians/NPPs when their scope of practice, state and local laws allow it and their personal professional training is judged by Medicare contractors as sufficient to provide to the beneficiary skills equivalent to a therapist for that service.

COMPLEXITIES are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses (ICD codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

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

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

During the episode, the beneficiary may be treated for more than one condition; including conditions with an onset after the episode has begun. For example, a beneficiary receiving PT for a hip fracture who, after the initial treatment session, develops low back pain would also be treated under a PT plan of care for rehabilitation of low back pain. That plan may be modified from the initial plan, or it may be a separate plan specific to the low back pain, but treatment for both conditions concurrently would be considered the same episode of PT treatment. If that same patient developed a swallowing problem during intubation for the hip surgery, the first day of treatment by the SLP would be a new episode of SLP care.

EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

FUNCTIONAL REPORTING, which is required on claims for all outpatient therapy services pursuant to 42CFR410.59, 410.60, and 410.62, uses nonpayable G-codes and related modifiers to convey information about the patient's functional status at specified points during therapy. (See Pub 100-04, chapter 5, section 10.6) ***NOTE: Functional reporting requirements are no longer applicable for claims for dates of service on and after January 1, 2019. See the NOTE at the beginning of Section 220.4 for more information about the discontinuation of functional reporting requirements.***

RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, reevaluations must also meet Medicare coverage guidelines. The decision to provide a reevaluation shall be made by a clinician.

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

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

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

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

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

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

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (see section 230.1 and 230.2) and may not supervise other therapy caregivers.

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

SIGNATURE means a legible identifier of any type acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.3.2.4 concerning signatures.

SUPERVISION LEVELS for outpatient rehabilitation therapy services are the same as those for diagnostic tests defined in 42CFR410.32. Depending on the setting, the levels include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701-729, and 486.150-163.

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

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

Therapy services referred to in this chapter are those skilled services furnished according to the standards and conditions in CMS manuals, (e.g., in this chapter and in Pub. 100-04, Medicare Claims Processing Manual, chapter 5), within their scope of practice by qualified professionals or qualified personnel, as defined in this section, represented by procedures found in the American Medical Association's "Current Procedural Terminology (CPT)." A list of CPT (HCPCS) codes is provided in Pub. 100-04, chapter 5, §20, and in Local Coverage Determinations developed by contractors.

TREATMENT DAY means a single calendar day on which treatment, evaluation and/or reevaluation is provided. There could be multiple visits, treatment sessions/encounters on a treatment day.

VISITS OR TREATMENT SESSIONS begin at the time the patient enters the treatment area (of a building, office, or clinic) and continue until all services (e.g., activities, procedures, services) have been completed for that session and the patient leaves that area to participate in a non-therapy activity. It is likely that not all minutes in the visits/treatment sessions are billable (e.g., rest periods). There may be two treatment sessions in a day, for example, in the morning and afternoon. When there are two visits/ treatment sessions in a day, plans of care indicate treatment amount of twice a day.

B. References

Paper Manuals. The following manuals, now outdated, were resources for the Internet Only Manuals:

- Part A Medicare Intermediary Manual, (Pub. 13)
- Part B Medicare Carrier Manual, (Pub. 14)
- Hospital Manual, (Pub. 10)
- Outpatient Physical Therapy/CORF Manual, (Pub. 9)

Regulation and Statute. The information in this section is based in part on the following current references:

- 42CFR refers to Title 42, Code of Federal Regulation (CFR).
- The Act refers to the Social Security Act.

Internet Only Manuals. Current Policies that concern providers and suppliers of therapy services are located in many places throughout CMS Manuals. Sites that may be of interest include:

- Pub.100-01 GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT
 - Chapter 1- General Overview
 - 10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and SNF Services - A Brief Description
 - 10.2 - Home Health Services
 - 10.3 - Supplementary Medical Insurance (Part B) - A Brief Description
 - 20.2 - Discrimination Prohibited
- Pub. 100-02, MEDICARE BENEFIT POLICY MANUAL
 - Ch 6 - Hospital Services Covered Under Part B
 - 10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals

- 20 - Outpatient Hospital Services
- 20.2 - Outpatient Defined
- 20.4.1 - Diagnostic Services Defined
- 70 - Outpatient Hospital Psychiatric Services

- Ch 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

- 30.4. - Direct Skilled Rehabilitation Services to Patients
- 40 - Physician Certification and Recertification for Extended Care Services
- 50.3 - Physical Therapy, Speech-Language Pathology, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements with the Facility and Under Its Supervision
- 70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services

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

10 - Comprehensive Outpatient Rehabilitation Facility (CORF) Services Provided by Medicare

20 - Required and Optional CORF Services

- 20.1 - Required Services

- 20.2 - Optional CORF Services

30 - Rules for Provision of Services

- 30.1 - Rules for Payment of CORF Services

40 - Specific CORF Services

- 40.1 - Physicians' Services

- 40.2 - Physical Therapy Services

- 40.3 - Occupational Therapy Services

- 40.4 - Speech Language Pathology Services

- Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL

- Part 1

- 20.10 - Cardiac Rehabilitation Programs

- 30.1 - Biofeedback Therapy

- 30.1.1 - Biofeedback Therapy for the Treatment of Urinary Incontinence

- 50.1 - Speech Generating Devices

- 50.2 - Electronic Speech Aids

- 50.4 - Tracheostomy Speaking Valve

- Part 2

- 150.2 - Osteogenic Stimulator

- 160.7 - Electrical Nerve Stimulators

- 160.12 - Neuromuscular Electrical Stimulation (NMES)

- 160.13 - Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)

- 160.17 - L-Dopa

- Part 3

- 170.1 - Institutional and Home Care Patient Education Programs

- 170.2 - Melodic Intonation Therapy

- 170.3 - Speech Pathology Services for the Treatment of Dysphagia

- 180 - Nutrition

- Part 4

- 230.8 - Non-implantable Pelvic Flood Electrical Stimulator

- 240.7 - Postural Drainage Procedures and Pulmonary Exercises

- 270.1 -Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds

- 270.4 - Treatment of Decubitus Ulcers

- 280.3 - Mobility Assisted Equipment (MAE)

- 280.4 - Seat Lift

- 280.13 - Transcutaneous Electrical Nerve Stimulators (TENS)

- 290.1 - Home Health Visits to A Blind Diabetic

- Pub. 100-08 PROGRAM INTEGRITY MANUAL

- Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

- 3.4.1.1 - Linking LCD and NCD ID Numbers to Edits

- Chapter 13 - Local Coverage Determinations

- 13.5.1 - Reasonable and Necessary Provisions in LCDs

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

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

C. General

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

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

Where a prospective payment system (PPS) applies, therapy services are paid when services conform to the requirements of that PPS. Reimbursement for therapy provided to Part A inpatients of hospitals or residents of SNFs in covered stays is included in the respective PPS rates.

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

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

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

220.1 - Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services *(Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)*

Reference: 42CFR424.24

Refer to §230.4 for physical therapist/occupational therapist in private practice rules.

Coverage rules for specific services are in Pub. 100-03, Medicare National Coverage Determinations Manual.

Other payment rules are found in Pub. 100-04, Medicare Claims Processing Manual, chapter 5.

Since the outpatient therapy benefit under Part B provides coverage only of therapy services, payment can be made only for those services that constitute therapy. In cases where there is doubt about whether a service is therapy, the contractor's local coverage determination (LCD) shall prevail.

In order for a service to be covered, it must have a benefit category in the statute, it must not be excluded and it must be reasonable and necessary. Therapy services are a benefit under §1861 of the Act. Consult Pub. 100-08, chapter 13, §13.5.1 for full descriptions of a reasonable and necessary service.

Outpatient therapy services furnished to a beneficiary by a provider or supplier are payable only when furnished in accordance with certain conditions. The following conditions apply.

- Services are or were required because the individual needed therapy services (see 42CFR424.24(c),§220.1.3);
- A plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP* (see 42CFR424.24(c), §220.1.2);
- Services are or were furnished while the individual is or was under the care of a physician* (see 42CFR424.24(c), §220.1.1);
- In certifying an outpatient plan of care for therapy a physician/NPP is certifying that the above three conditions are met (42 CFR 424.24(c)). Certification is required for coverage and payment of a therapy claim.
- Claims submitted for outpatient (and CORF) PT, OT, and SLP services must contain the National Provider (NPI) of the certifying physician identified for a PT, OT, and SLP plan of care. This

requirement is effective for claims with dates of service on or after October 1, 2012. (See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.3.)

- Claims submitted for outpatient (and CORF) PT, OT, and SLP services must contain the required functional reporting. (See 42CFR410.59, 60, and 62), Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6.) *NOTE: The applicable regulatory provisions were removed through the CY 2019 PFS final rule, CMS-1693-F. Functional reporting requirements are no longer applicable for claims for dates of service on and after January 1, 2019. See the NOTE at the beginning of Section 220.4 for more information.*
- The patient functional limitations(s) reported on claims, as part of the functional reporting, must be consistent with the functional limitations identified as part of the therapy plan of care and expressed as part of the patient's long term goals* (see 42CFR410.61, 42CFR410.105, Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6.) *NOTE: The applicable regulatory provisions were removed through the CY 2019 PFS final rule, CMS-1693-F. Functional reporting and its documentation requirements are no longer applicable for claims or medical records for dates of service on and after January 1, 2019.*

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

(Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

Reference: 42CFR 410.61 and 410.105(c) (for CORFs)

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, 410.61, and 410.105(c) (for CORFs)). (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. Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care. If the expected episode of care is short, for example therapy is expected to be completed in 4 to 6 treatment days, the long term and short term goals may be the same. In other instances measurable goals may not be achievable, such as when treatment in a particular setting is unexpectedly cut short (such as when care is transferred to another therapy provider) or when the beneficiary suffers an exacerbation of his/her existing condition terminating the current episode; documentation should state the clinical reasons progress cannot be shown. The functional impairments identified and expressed in the long term treatment goals must be consistent with those used in the claims-based functional reporting, using nonpayable G-codes and severity modifiers, for services furnished on or after January 1, 2013. (Reference: 42CFR410.61 and 42CFR410.105 (for CORFs). ***NOTE: The regulatory requirements at 42CFR410.61 and 42CFR410.105 (for CORFs) for the plan of care's long-term goals to be consistent with functional impairments identified for purposes of functional reporting, were removed by the CY 2019 Physician Fee Schedule final rule, CMS-1693-F. Functional reporting and its associated documentation requirements are no longer applicable for claims or medical records for dates of service on and after January 1, 2019. See the NOTE at the beginning of Section 220.4 for more information.***

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).

220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services

(Rev.)

References: Pub. 100-08, chapter 13, §13.5.1,
42CFR410.59,
42CFR410.60

A. General

To be covered, services must be skilled therapy services as described in this chapter and be rendered under the conditions specified. Services provided by professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services. A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. For further information see 220.2, subsections C (Rehabilitative Services) and subsection D (Maintenance Programs).

Services that do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions as therapy services. For example, services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes. Also, services not provided under a therapy plan of care, or provided by staff who are not qualified or appropriately supervised, are not payable therapy services.

Examples of coverage policies that apply to all outpatient therapy claims are in this chapter, in Pub. 100-04, chapter 5, and Pub. 100-08, chapter 13. Some policies in other manuals are repeated here for emphasis and clarification. Further details on documenting reasonable and necessary services are found in section 220.3 of this chapter.

B. Reasonable and Necessary

To be considered reasonable and necessary, each of the following conditions must be met. (This is a representative list of required conditions and does not fully describe reasonable and necessary services. See the remainder of this section and associated information in section 230.)

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:
 - Medicare manuals (such as this manual and Publications 100-03 and 100-04),
 - Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd>, and
 - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional. Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. (For additional guidance, see subsection D below related to Maintenance Programs.)
- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, the contractor shall presume that such services were properly supervised when required. However, this presumption is rebuttable and, if in the course of processing a claim, the contractor finds that services were not furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.
- While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See items C and D for descriptions of covered skilled services; and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

NOTE: Claims for therapy services denied because they are not considered reasonable and necessary under §1862(a)(1)(A) of the Act and, for services furnished on or after January 1, 2013, those denied as a result of application of the therapy caps under §1833(g)(1) or (g)(3) are subject to consideration under the waiver of liability provision in §1879 of the Act. *Although Section 50202 of the Bipartisan Budget Act (BBA) of 2018 repealed the therapy caps and its exceptions process effective January 1, 2018, it did not change provider liability procedures which first became effective January 1, 2013. Section 1833(g)(8) of the Social Security Act (as redesignated by the BBA of 2018) continues to provide limitation of liability (LOL) protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied for certain reasons, including failure to include a necessary –KX modifier. (Section 1879 provides LOL protections for reasonable and necessary denials more generally.) Under section §1833(g)(8), the therapist or therapy provider is financially liable for the cost of therapy services provided to a beneficiary above the threshold amount when Medicare denies payment for failure to use the –KX modifier to indicate that the services are medically necessary as justified by documentation in the medical record. In order for the therapist or therapy provider to transfer liability to the beneficiary, s/he must issue a valid ABN, Form CMS-R-131. For more information, see the Therapy Services webpage at: <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html> for the Advance Beneficiary Notice of Noncoverage (ABN) Frequently Asked Questions (FAQ) document that was posted to reflect the changes of the Bipartisan Budget Act of 2018. Please find the document titled: “August 2018 ABN FAQs” in the Downloads section on this webpage.*

C. Rehabilitative Therapy

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive objective measurements whenever possible (see objective measurement and other instruments for evaluation in the §220.3.C of this chapter). If an individual’s expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

Rehabilitative therapy services are skilled procedures that may include but are not limited to:

- Evaluations and reevaluations;
- Establishment of treatment goals specific to the patient’s disability or dysfunction and designed to specifically address each problem identified in the evaluation;
- Design of a plan of care addressing the patient’s disorder, including establishment of procedures to obtain goals, determining the frequency and intensity of treatment;
- Continued assessment and analysis during implementation of the services at regular intervals;
- Instruction leading to establishment of compensatory skills;
- Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system); and
- Training of patient and family to augment rehabilitative treatment. Training of staff and family should be ongoing throughout treatment and instructions modified intermittently as the patient’s status changes.

Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. (See definition of therapist in

section 220.A of this chapter.) Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services.

Rehabilitative therapy may be needed, and improvement in a patient's condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition or to maximize his/her functional abilities. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel.

Rehabilitative therapy is not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary and generalized weakness, which may follow a brief period of bed rest following surgery) that could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered.

If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, the services will no longer be considered reasonable and necessary under this section. (See Section 220.2 D for additional covered therapy benefits under maintenance programs). Services that are not reasonable or necessary are excluded from coverage under §1862(a)(1)(A) of the Act.

D. Maintenance Programs

Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

Coverage for skilled therapy services related to a reasonable and necessary maintenance program is available in the following circumstances:

- **Establishment or design of maintenance programs.** If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.
- **Delivery of maintenance programs.** Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary's need for skilled care. A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided. However, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program. Such skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the therapy procedures required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or (b) the particular patient's special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient's current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures. Unlike coverage for

rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient's potential for improvement from the therapy.

The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel or caregivers.

The examples that follow are intended to provide illustrations of how coverage determinations are made. These examples are not intended to include all possible situations in which coverage is provided or all reasons for denying coverage. Rather they are intended only to show how to analyze the coverage issue.

Example #1 reflects a typical outpatient scenario in which a patient has been receiving ongoing therapy under a physical therapy plan of care and the physical therapist begins the establishment of the maintenance program prior to the patient's anticipated discharge date.

EXAMPLE: A patient with Parkinson's disease is nearing the end of a rehabilitative physical therapy program and requires the services of a therapist during the last week(s) of treatment to determine what type of exercises will contribute the most to maintain function or to prevent or slow further deterioration of the patient's present functional level following cessation of treatment. In such situations, the establishment of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist, the instruction of the patient or family members in carrying out the program, and such reassessments and/or reevaluations as may be required may constitute covered therapy because of the need for the skills of a qualified therapist.

Example #2 is an outpatient scenario in which a patient who has not been receiving ongoing therapy under a therapy plan of care needs a maintenance plan.

EXAMPLE: A patient with multiple sclerosis needs a maintenance program to slow or prevent deterioration in communication ability caused by the medical condition. Therapy services from a qualified speech-language pathologist may be covered to establish a maintenance program even though the patient's current medical condition does not yet justify the need for individual skilled therapy sessions. Evaluation, establishment of the program, and training the family or support personnel may require the skills of a therapist and would be covered. **NOTE:** In this example, the skills of a therapist are not required to actually carry out the maintenance program services and, as a result, are not covered.

Example #3 describes a scenario where the skilled services of a therapist would be necessary to actually carry out the maintenance program services.

EXAMPLE: Where there is an unhealed, unstable fracture that requires regular exercise to maintain function until the fracture heals, the skills of a therapist may be needed to ensure that the fractured extremity is maintained in proper position and alignment during range of motion exercises. In this case, since the skills of a therapist may be required to safely carry out the maintenance program given this particular patient's special medical complications, therapy services would be covered.

Example #4 describes another scenario where the skilled services of a therapist are needed to actually carry out the maintenance program services.

EXAMPLE: A patient with a long history of Multiple Sclerosis has difficulties transferring in and out of the wheelchair and maintaining range of motion (ROM) of the lower extremities (LEs) due to increased spasticity muscle tone since the most recent exacerbation episode of her Multiple Sclerosis. The beneficiary is unable to walk but is independent with the use of her wheelchair. The beneficiary needs to be able to safely transfer in and out of her wheelchair by herself or with the assistance of a family member or other caregiver(s). After an individualized assessment by the physical therapist, and given the patient's overall medical and physical condition, the skills of the physical therapist are required to instruct the patient and/or caregivers in proper techniques of wheelchair transfers and LE

stretches due to the special medical complications from the progression of Multiple Sclerosis. When the physical therapist determines that the patient can carry out the transfers and stretching activities safely and effectively, either alone or with the assistance of the caregivers, the skills of the physical therapist are no longer necessary to furnish the maintenance therapy; and, the patient is discharged from PT.

Example #5 describes a scenario where a patient on a maintenance program needs intermittent review and possibly a new or revised maintenance program.

EXAMPLE: A patient who has a progressive degenerative disease is performing the activities in a maintenance program established by a therapist with the assistance of family members. The program needs to be re-evaluated to determine whether assistive equipment is needed and to establish a new or revised maintenance program to maintain function or to prevent or slow further deterioration. Intermittent re-evaluation of the maintenance program would generally be covered as this is a service that requires the skills of a therapist. Should the therapist conducting the re-evaluation determine that the program needs to be revised, these services would generally be covered.

Maintenance program services that do not meet the criteria of this section are not reasonable or necessary and are not covered under §1862(a)(1)(A) of the Act.

The maintenance program provisions outlined in this section do not apply to the PT, OT, or SLP services furnished in a comprehensive outpatient rehabilitation facility (CORF) because the statute specifies that CORF services are rehabilitative.

220.3 - Documentation Requirements for Therapy Services

(Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

A. General

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

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

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

B. Documentation Required

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

- Evaluation and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;
- Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due.
- Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due. (See definitions in section 220 and descriptions in 220.3 D);
- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes);
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

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

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

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

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

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

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

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

- Services require the skills of a therapist.

Services must not only be provided by the qualified professional or qualified personnel, but they must require, for example, the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently. A clinician may not merely supervise, but must apply the skills of a therapist by actively participating in the treatment of the patient during each progress report period. In addition, a therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.

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

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

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

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

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

- Functional information included on claims as required.

The clinician is required to document in the patient's medical record, using the G-codes and severity modifiers used in functional reporting, the patient's current, projected goal, and discharge status, as reported pursuant to functional reporting requirements for each date of service for which the reporting is required. See section 220.4 below for details on documenting G-code and modifiers. ***NOTE: Functional reporting and its associated documentation requirements are no longer applicable for claims or medical records for dates of service on and after January 1, 2019. See the NOTE at the beginning of Section 220.4 for more information.***

C. Evaluation/Re-Evaluation and Plan of Care

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

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

Evaluation shall include:

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

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

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

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

Activity Measure – Post Acute Care (AM-PAC)

OPTIMAL by Cedaron through the American Physical Therapy Association

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

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

- Identification of other health services concurrently being provided for this condition (e.g., physician, PT, OT, SLP, chiropractic, nurse, respiratory therapy, social services, psychology, nutritional/dietetic services, radiation therapy, chemotherapy, etc.), and/ or

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

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

- Record of discharge from a Part A qualifying inpatient, SNF, or home health episode within 30 days of the onset of this outpatient therapy episode, or
- Identification of whether beneficiary was treated for this same condition previously by the same therapy discipline (regardless of where prior services were furnished; and
- Record of a previous episode of therapy treatment from the same or different therapy discipline in the past year.

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

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

Documentation required to indicate beneficiary social support including, specifically,

- Where does the beneficiary live (or intend to live) at the conclusion of this outpatient therapy episode? (e.g., private home, private apartment, rented room, group home, board and care apartment, assisted living, SNF), and

- Who does beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode? (e.g., lives alone, spouse/significant other, child/children, other relative, unrelated person(s), personal care attendant), and
- Does the beneficiary require this outpatient therapy plan of care in order to return to a premorbid (or reside in a new) living environment, and
- Does the beneficiary require this outpatient therapy plan of care in order to reduce Activities of Daily Living (ADL) or Instrumental Activities of Daily Living or (IADL) assistance to a premorbid level or to reside in a new level of living environment (document prior level of independence and current assistance needs); and

*Documentation required to indicate objective, measurable beneficiary physical function including, e.g.,

- Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
 - Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
 - Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.
- Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and
 - A determination that treatment is not needed, or, if treatment is needed a prognosis for return to premorbid condition or maximum expected condition with expected time frame and a plan of care.

NOTE: When the Evaluation Serves as the Plan of Care. When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. A referral/order dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient.

The time spent in evaluation shall not also be billed as treatment time. Evaluation minutes are untimed and are part of the total treatment minutes, but minutes of evaluation shall not be included in the minutes for timed codes reported in the treatment notes.

Re-evaluations shall be included in the documentation sent to contractors when a re-evaluation has been performed. See the definition in section 220. Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a

significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued.

A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation. The minutes for re-evaluation are documented in the same manner as the minutes for evaluation. Current Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code.

Plan of Care. See section 220.1.2 for requirements of the plan. The evaluation and plan may be reported in two separate documents or a single combined document.

D. Progress Report

The progress report provides justification for the medical necessity of treatment.

Contractors shall determine the necessity of services based on the delivery of services as directed in the plan and as documented in the treatment notes and progress report. For Medicare payment purposes, information required in progress reports shall be written by a clinician that is, either the physician/NPP who provides or supervises the services, or by the therapist who provides the services and supervises an assistant. It is not required that the referring or supervising physician/NPP sign the progress reports written by a PT, OT or SLP.

Timing. The minimum progress report period shall be at least once every 10 treatment days. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation or treatment. Regardless of the date on which the report is actually written (and dated), the end of the progress report period is either a date chosen by the clinician or the 10th treatment day, whichever is shorter. The next treatment day begins the next reporting period. The progress report period requirements are complete when both the elements of the progress report and the clinician's active participation in treatment have been documented.

For example, for a patient evaluated on Monday, October 1 and being treated five times a week, on weekdays: On October 5, (before it is required), the clinician may choose to write a progress report for the last week's treatment (from October 1 to October 5). October 5 ends the reporting period and the next treatment on Monday, October 8 begins the next reporting period. If the clinician does not choose to write a report for the next week, the next report is required to cover October 8 through October 19, which would be 10 treatment days.

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

Absences. Holidays, sick days or other patient absences may fall within the progress report period. Days on which a patient does not encounter qualified professional or qualified personnel for treatment, evaluation or re-evaluation do not count as treatment days. However, absences do not affect the requirement for a progress report at least once during each progress report period. If the patient is absent unexpectedly at the end of the reporting period, when the clinician has not yet provided the required active participation during

that reporting period, a progress report is still required, but without the clinician's active participation in treatment, the requirements of the progress report period are incomplete.

Delayed Reports. If the clinician has not written a progress report before the end of the progress reporting period, it shall be written within 7 calendar days after the end of the reporting period. If the clinician did not participate actively in treatment during the progress report period, documentation of the delayed active participation shall be entered in the treatment note as soon as possible. The treatment note shall explain the reason for the clinician's missed active participation. Also, the treatment note shall document the clinician's guidance to the assistant or qualified personnel to justify that the skills of a therapist were required during the reporting period. It is not necessary to include in this treatment note any information already recorded in prior treatment notes or progress reports.

The contractor shall make a clinical judgment whether continued treatment by assistants or qualified personnel is reasonable and necessary when the clinician has not actively participated in treatment for longer than one reporting period. Judgment shall be based on the individual case and documentation of the application of the clinician's skills to guide the assistant or qualified personnel during and after the reporting period.

Early Reports. Often, progress reports are written weekly, or even daily, at the discretion of the clinician. Clinicians are encouraged, but not required to write progress reports more frequently than the minimum required in order to allow anyone who reviews the records to easily determine that the services provided are appropriate, covered and payable.

Elements of progress reports may be written in the treatment notes if the provider/supplier or clinician prefers. If each element required in a progress report is included in the treatment notes at least once during the progress report period, then a separate progress report is not required. Also, elements of the progress report may be incorporated into a revised plan of care when one is indicated. Although the progress report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the revised plan of care accompanied by the progress report shall be re-certified by a physician/NPP. See section 220.1.2C, Changes to the Therapy Plan, for guidance on when a revised plan requires certification.

Progress Reports for Services Billed Incident to a Physician's Service. The policy for incident to services requires, for example, the physician's initial service, direct supervision of therapy services, and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment (see section 60.1B of this chapter. Also, see the billing requirements for services incident to a physician in Pub. 100-04, chapter 26, Items 17, 19, 24, and 31.) Therefore, supervision and reporting requirements for supervising physician/NPPs supervising staff are the same as those for PTs and OTs supervising PTAs and OTAs with certain exceptions noted below.

When a therapy service is provided by a therapist, supervised by a physician/NPP and billed incident to the services of the physician/NPP, the progress report shall be written and signed by the therapist who provides the services.

When the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each progress report period and sign the progress report.

Documenting Clinician Participation in Treatment in the Progress Report. Verification of the clinician's required participation in treatment during the progress report period shall be documented by the clinician's signature on the treatment note and/or on the progress report. When unexpected discontinuation of treatment occurs, contractors shall not require a clinician's participation in treatment for the incomplete reporting period.

The Discharge Note (or Discharge Summary) is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation

meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The discharge note shall be a progress report written by a clinician, and shall cover the reporting period from the last progress report to the date of discharge. In the case of a discharge unanticipated in the plan or previous progress report, the clinician may base any judgments required to write the report on the treatment notes and verbal reports of the assistant or qualified personnel.

In the case of a discharge anticipated within 3 treatment days of the progress report, the clinician may provide objective goals which, when met, will authorize the assistant or qualified personnel to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist, and services were provided or supervised by a clinician. The discharge note shall include all treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge.

At the discretion of the clinician, the discharge note may include additional information; for example, it may summarize the entire episode of treatment, or justify services that may have extended beyond those usually expected for the patient's condition. Clinicians should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed. The record should be reviewed and organized so that the required documentation is ready for presentation to the contractor if requested.

Assistant's Participation in the Progress Report. PTAs or OTAs may write elements of the progress report dated between clinician reports. Reports written by assistants are not complete progress reports. The clinician must write a progress report during each progress report period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the clinician's report. Progress reports written by assistants supplement the reports of clinicians and shall include:

- Date of the beginning and end of the reporting period that this report refers to;
- Date that the report was written (not required to be within the reporting period);
- Signature, and professional identification, or for dictated documentation, the identification of the qualified professional who wrote the report and the date on which it was dictated;
- Objective reports of the patient's subjective statements, if they are relevant. For example, "Patient reports pain after 20 repetitions". Or, "The patient was not feeling well on 11/05/06 and refused to complete the treatment session."; and
- Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively. For example: "increasing strength" is not an objective measurement, but "patient ambulates 15 feet with maximum assistance" is objective.

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the progress report may be used to add, change or delete short term goals. Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name, and date. Clinicians verify these changes by co-signatures on the report or in the clinician's progress report. (See section 220.1.2(C) to modify the plan for changes in long term goals).

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

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

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.
- Functional documentation is required as part of the progress report at the end of each progress reporting period. It is also required at the time of discharge on the discharge note or summary, as applicable. The clinician documents, on the applicable dates of service, the specific nonpayable G-codes and severity modifiers used in the required reporting of the patient's functional limitation(s) on the claim for services, including how the modifier selection was made. See subsection C of 220.4 below for details relevant to documentation requirements.

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

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

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.

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

Example: The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink thick liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks. Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia. Short Term Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials. Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%. The progress report for 1/3/06 to 1/29/06 states: 1. Improved to 80% of trials; 2. Achieved. Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions. New

Goal: “5. Patient will implement above strategies to swallow a sip of water without coughing for 5 consecutive trials. Mary Johns, CCC-SLP, 1/29/06.” Note the provider is billing 92526 three times a week, consistent with the plan; progress is documented; skilled treatment is documented.

E. Treatment Note

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

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

Documentation of each treatment shall include the following required elements:

- Date of treatment; and
- Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and
- Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, chapter 5, section 20.2 for description of billing timed codes; and
- Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment (i.e., the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law). The signature and identification of the supervisor need not be on each treatment note, unless the supervisor actively participated in the treatment. Since a clinician must be identified on the plan of care and the progress report, the name and professional identification of the supervisor responsible for the treatment is assumed to be the clinician who wrote the plan or report. When the treatment is supervised without active participation by the supervisor, the supervisor is not required to cosign the treatment note written by a qualified professional. When the responsible supervisor is absent, the presence of a similarly qualified supervisor on the clinic roster for that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation.

If a treatment is added or changed under the direction of a clinician during the treatment days between the progress reports, the change must be recorded and justified on the medical record, either in the treatment note or the progress report, as determined by the policies of the provider/supplier. New exercises added or changes made to the exercise program help justify that the services are skilled. For example: The original

plan was for therapeutic activities, gait training and neuromuscular re-education. “On Feb. 1 clinician added electrical stim. to address shoulder pain.”

Documentation of each treatment may also include the following optional elements to be mentioned only if the qualified professional recording the note determines they are appropriate and relevant. If these are not recorded daily, any relevant information should be included in the progress report.

- Patient self-report;
- Adverse reaction to intervention;
- Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.);
- Significant, unusual or unexpected changes in clinical status;
- Equipment provided; and/or
- Any additional relevant information the qualified professional finds appropriate.

See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 20.2 for instructions on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes.

220.4 – Functional Reporting

(Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

***NOTE:** In the calendar year (CY) 2019 Physician Fee Schedule (PFS) final rule, CMS-1693-F, after consideration of stakeholder comments for burden reduction, a review of all of the requirements under section 3005(g) of Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA), and in light of the statutory amendments to section 1833(g) of the Act, via section 50202 of Bipartisan Budget Act of 2018 to repeal the therapy caps, CMS concluded that continued collection of functional reporting data through the same or reduced format would not yield additional information to inform future analyses or to serve as a basis for reforms to the payment system for therapy services. To reduce the burden of reporting for providers of therapy services, the CY 2019 PFS final rule ended the requirements of reporting the functional limitation nonpayable HCPCS G-codes and severity modifiers on claims for therapy services and the associated documentation requirements in medical records, effective for dates of service on and after January 1, 2019. The rule also revised regulation text at 42 CFR 410.59, 410.60, 410.61, 410.62, 410.105, accordingly.*

The instructions below apply only to dates of service when the functional reporting requirements were effective, January 1, 2013 through December 31, 2018.

A. Selecting the G-codes to Use in Functional Reporting.

There are 42 functional G-codes, 14 sets of three codes each, for that can be used in identifying the functional limitation being reported. Six of the G-code sets are generally for PT and OT functional limitations and eight sets of G-codes are for SLP functional limitations. (For a list of these codes and descriptors, see Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6 F.)

Only one functional limitation shall be reported at a time. Consequently, the clinician must select the G-code set for the functional limitation that most closely relates to the primary functional limitation being treated or the one that is the primary reason for treatment. When the beneficiary has more than one functional limitation, the clinician may need to make a determination as to which functional limitation is primary. In these cases, the clinician may choose the functional limitation that is:

- Most clinically relevant to a successful outcome for the beneficiary;
- The one that would yield the quickest and/or greatest functional progress; or
- The one that is the greatest priority for the beneficiary.

In all cases, this primary functional limitation should reflect the predominant limitation that the furnished therapy services are intended to address.

For services typically reported as PT or OT, the clinician reports one of the “Other PT/OT” functional G-codes sets to report when one of the four PT/OT categorical code sets does not describe the beneficiary’s functional limitation, as follows:

- a beneficiary’s functional limitation that is not defined by one of the four categories;
- a beneficiary whose therapy services are not intended to treat a functional limitation; or
- a beneficiary’s functional limitation where an overall, composite, or other score from a functional assessment tool is used and does not clearly represent a functional limitation defined by one of the above four categorical PT/OT code sets.

In addition, the subsequent “Other PT/OT” G-code set is only reported after the primary “Other PT/OT” G-code set has been reported for the beneficiary during the same episode of care.

For services typically reported as SLP services, the clinician uses the “Other SLP” functional G-code to report when the functional limitation being treated is not represented by one of the seven categorical SLP functional measures. In addition, the “Other SLP” G-code set is used to report where an overall, composite, or other score from an assessment tool that does not clearly represent a functional limitation defined by one of the seven categorical SLP measures.

B. Selecting the severity modifiers to use in functional reporting/documenting.

Each G-code requires one of the following severity modifiers. When the clinician reports any of the following a modifier is used to convey the severity of the functional limitation: current status, the goal status and the discharge status.

Modifier	Impairment Limitation Restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

The severity modifier reflects the beneficiary’s percentage of functional impairment as determined by the clinician furnishing the therapy services for each functional status: current, goal, or discharge. In selecting the severity modifier, the clinician:

- Uses the severity modifier that reflects the score from a functional assessment tool or other performance measurement instrument, as appropriate.
- Uses his/her clinical judgment to combine the results of multiple measurement tools used during the evaluative process to inform clinical decision making to determine a functional limitation percentage.

- Uses his/her clinical judgment in the assignment of the appropriate modifier.
- Uses the CH modifier to reflect a zero percent impairment when the therapy services being furnished are not intended to treat (or address) a functional limitation.

In some cases the modifier will be the same for current status and goal status. For example: where improvement is expected but it is not expected to be enough to move to another modifier, such as from 10 percent to 15 percent, the same severity modifier would be used in reporting the current and goal status. Also, when the clinician does not expect improvement, such as for individuals receiving maintenance therapy, the modifier used for projected goal status will be the same as the one for current status. In these cases, the discharge status may also include the same modifier.

Therapists must document in the medical record how they made the modifier selection so that the same process can be followed at succeeding assessment intervals.

C. Documentation of G-code and Severity Modifier Selection.

Documentation of the nonpayable G-codes and severity modifiers regarding functional limitations reported on claims must be included in the patient's medical record of therapy services for each required reporting. (See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6 for details about the functional reporting requirements on claims for therapy services, including PT, OT, and SLP services furnished in CORFs.)

Documentation of functional reporting in the medical record of therapy services must be completed by the clinician furnishing the therapy services:

- The qualified therapist furnishing the therapy services
- The physician/NPP personally furnishing the therapy services
- The qualified therapist furnishing services incident to the physician/NPP
- The physician/NPP for incident to services furnished by qualified personnel, who are not qualified therapists.

The qualified therapist furnishing the PT, OT, or SLP services in a CORF