CMS Manual System

Pub 100-02 Medicare Benefit Policy

Transmittal 36

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JUNE 24, 2005

Change Request 3648

Transmittal 34, CR 3648, issued on May 6, 2005 is rescinded and replaced with Transmittal 36, dated June 24, 2005 to correct the transmittal page. The deletion of sections 220.3, 220.3.1, 220.3.2, 220.3.3 and 220.3.4 from the Internet Only Manual was erroneously omitted from the transmittal page. The information contained in the deleted sections was incorporated into other sections in the manual. All other information remains the same.

SUBJECT: Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy Services

I. SUMMARY OF CHANGES: This change request is a re-organization of sections 220 and 230. It clarifies policies concerning orders, visits, plans of care, certifications, and private practice. It manualizes the information in the Final Rule of November 15, 2004 concerning the definition of therapy services, the qualifications of therapists, therapy services provided incident to a physician must meet the standards for therapists, except licensure, and supervision in private practice settings. It makes instructions in all sections conform. It omits the requirement for a physician visit prior to certification.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : **June 6, 2005**

IMPLEMENTATION DATE : **June 6, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/Table of Contents
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
N	15/220.1.1/Outpatient Therapy Must be Under the Care of a Physician/Nonphysician Practitioners (NPP) (Orders/Referrals and Need for Care)
N	15/220.1.2/Plans of Care for Outpatient Physical Therapy, Occupational Therapy or Speech-Language Pathology Services
N	15/220.1.3/Certification and Recertification of Need for Treatment and Therapy Plans of Care
N	15/220.1.4/Requirement that Services be Furnished on an Outpatient Basis
R	15/220.2/Reasonable and Necessary Outpatient Rehabilitation Therapy Services
D	15/220.3/Conditions for Coverage of Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
D	15/220.3.1/Physician's Certification and Recertification
D	15/220.3.2/Outpatient Must be Under Care of Physician
D	15/220.3.3/Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services Furnished Under Plan
D	15/220.3.4/Requirement That Services Be Furnished on an Outpatient Basis
R	15/230/Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
R	15/230.1/Practice of Physical Therapy
R	15/230.2/Practice of Occupational Therapy
R	15/230.3/Practice of Speech-Language Pathology
R	15/230.4/Services Furnished by a Physical or Occupational Therapist in Private Practice
R	15/230.5/Physical therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Nonphysician Practitioners (NPP)
N	15/230.6/Therapy Services Furnished Under Arrangements with Providers and Clinics

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 36	Date: June 24, 2005	Change Request 3648

Transmittal 34, CR 3648, issued on May 6, 2005 is rescinded and replaced with Transmittal 36, dated June 24, 2005 to correct the transmittal page. The deletion of sections 220.3, 220.3.1, 220.3.2, 220.3.3 and 220.3.4 from the Internet Only Manual was erroneously omitted from the transmittal page. The information contained in the deleted sections was incorporated into other sections in the manual. All other information remains the same.

SUBJECT: Pub. 100-02 chapter 15, sections 220 and 230 Therapy Services

I. GENERAL INFORMATION

A. Background: This manual revision reorganizes the sections relevant to therapy, adds reference information, and clarifies current policy concerning physician visits and certification. It makes corrections to Transmittal 5, CRs 2859 and 2779 issued January 9, 2004. It also manualizes the statutory requirement that therapy provided incident to a physician's service must be provided by an individual meeting the same requirements as therapists, except licensure. CMS contractors shall implement policies in the manuals.

B. Policy: Analysis of claim errors suggests that the complexity and inconsistency in the documentation policies contribute to errors. Claims with errors are costly to administer, and burdensome to Medicare contractors and providers. Clarifications should improve compliance with certification rules, decrease the error rate, facilitate the review of claims for medical necessity, and provide a basis for alternative payment policies. Reduced errors would also benefit both providers and beneficiaries, by reducing unnecessary interruptions in treatment.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3648.1	Medicare contractors shall pay for therapy services only when the services meet the conditions and standards for therapy services described in the manuals.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3648.2	Contractors shall pay claims when documentation includes a certified plan of care (rather than an order or referral for therapy services).	X	X	X						
3648.3	Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or postpay review.	X	X	X						
3648.4	During either prepay or postpay review, contractors should deny claims if, after development, there is no documentation indicating physician/nonphysician practitioner certification of a therapy plan of care for each 30 day interval of treatment unless there is a delayed certification at any date, or unless the certification was not yet due for the service reviewed. This is a technical denial and the decision may be reopened by the contractor or reversed on appeal as appropriate, if delayed certification is later produced.	X	X	X						
3648.5	On prepay or postpay review of therapy claims, Medicare contractors shall count the days from the beginning of therapy (from the date first treated by the therapist) to determine if the certification of the plan is delayed.	X	X	X						
3648.6	Medicare contractors shall accept a certification or recertification that relates to the dates of service on the claim, if it is signed before, during or within 30 days after the date first treated by the therapist.	X	X	X						
3648.7	Medicare contractors shall accept delayed certifications unless the claim, the justification, or any accompanying documentation indicates the treatment was not clinically necessary (the service does not meet the patient's need) or the patient was not under the care of a physician during the time of the treatment.	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3648.8	Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals.	X	X	X						
3648.9	For services on or after January 1, 2005, for services provided by an assistant in a physical therapy (PT) or occupational therapy (OT) private practice contractors shall allow claims if there is a qualified physical therapist or occupational therapist in the office directly supervising the service.	X	X	X						
3648.10	Contractors shall deny payment for therapy service provided incident to a physician if the person who performed the service does not meet the qualifications for qualified therapists as defined in Medicare manuals, with the exception of the licensure requirement.	X	X	X						
3648.11	Medicare contractors shall be aware, when requesting documentation for review the certification for a service may not be required until after the service is performed and billed. Consult the Program Integrity manual for review guidelines.	X	X	X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3648.12	Provider education articles related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. There will be a separate article related to the incident to section. You will receive notification of the articles' release via the established "medlearn matters" listserv. Contractors shall post these articles, or a direct link to the articles, on their Web site and include information about them in a listserv message within 1 week of the availability of the provider education articles. In addition, the provider education articles shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: **N/A**

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: June 6, 2005 **Implementation Date:** June 6, 2005 **Pre-Implementation Contact(s):** Dorothy Shannon 410-786-3396 **Post-Implementation Contact(s):** Dorothy Shannon 410-786-3396	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents

(Rev.36, 06-24-05)

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

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

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 Web site of the contractor to whom the provider or supplier submits claims. A list of these contractors is found at the CMS Web site: www.cms.hhs.gov/medlearn/therapy. 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.

A - Definitions

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

ASSESSMENT is included in services or procedures and is not separately payable (as distinguished from Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment which may be payable). 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 and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgment about progress toward goals and/or determine that a more complete evaluation or reevaluation (see definitions below) is indicated.

CERTIFICATION is the physician's/NonPhysician Practitioner's (NPP) approval of the plan of care.

EVALUATION is a separately payable comprehensive service 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. The time spent in evaluation does not also count as treatment time.

REEVALUATION is separately payable and is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline in the patient's condition or functional status. Some regulations and state practice acts require reevaluation at specific intervals. Reevaluation may also be appropriate at a planned discharge. A reevaluation 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. Current Procedural Terminology does not define a reevaluation code for speech-language pathology; use the evaluation code.

INTERVAL of treatment consists of 1 month or 30 calendar days.

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.

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.

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants may not supervise others.

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

SIGNATURE means a legible identifier of any type (e.g., hand written, electronic, or signature stamp). Policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.4.1.1 (B) concerning signatures apply.

SUPERVISION LEVELS for outpatient rehabilitation therapy services are the same as those for diagnostic tests defined in 42CFR410.32. Depending on the setting, the levels

include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701-729, and 486.150-163. Speech-language pathologists are not suppliers because the Act does not provide coverage of any speech-language pathology services furnished by a speech-language pathologist as an independent practitioner. (See §230.3.)

THERAPIST refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, 230.2, and 230.3.

THERAPY, or outpatient rehabilitation services, includes only outpatient physical therapy, occupational therapy and speech-language pathology services paid using the Medicare Physician Fee Schedule.

Therapy services referred to in this manual are those skilled rehabilitative services provided according to the standards and conditions in CMS manuals, (e.g., in this chapter and in the Medicare Claims Processing Manual, Pub. 100-04, 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 and HCPCS codes is provided in Pub. 100-04, Chapter 5, §20, and in Local Coverage Determinations developed by contractors.

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

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 and SNF Services - A Brief Description

      10.2 - Posthospital Home Health Services

      10.3 - Supplementary Medical Insurance (Part B) - A Brief Description

      20.2 - Discrimination Prohibited
- *Pub. 100-02, MEDICARE BENEFIT POLICY MANUAL*
    - *Ch 6 - Hospital Services Covered Under Part B*

      10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals

      20 - Outpatient Hospital Services

      20.2 - Distinguishing Outpatient Hospital Services Provided Outside the Hospital

      20.4.1 - Coverage of Outpatient Therapeutic Services

      70 - Outpatient Hospital Psychiatric Services
    - *Ch 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance*

      30.4. - Direct Skilled Rehabilitation Services to Patients

      40 - Physician Certification and Recertification

      50.3 - Physical, Speech, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements with the Facility and Under Its Supervision

      70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services
- *Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL*
    - *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

150.4 - Neuromuscular Electrical Stimulator (NMES) in the Treatment of Disuse Atrophy

160.3 - Assessing Patient's Suitability for Electrical Nerve Stimulation

160.7 - Electrical Nerve Stimulators

160.11 - Osteogenic Stimulation

160.12 - Neuromuscular Electrical Stimulation (NMES)

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

160.17 - L-Dopa

- *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 - Specially Sized Wheelchairs

  280.4 - Seat Lift

  280.5 - Safety Roller

  280.9 - Power Operated Vehicles That May Be Used as Wheelchairs

  280.13 - Transcutaneous Electrical Nerve Stimulators (TENS)

  290.1 - Home Health Visits to A Blind Diabetic

- *Pub. 100-08 PROGRAM INTEGRITY MANUAL*
  - *Chapter 3 - Verifying Potential Errors and Taking Corrective Actions*

    3.4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

  - *Chapter 13 - Local Coverage Determinations*

    13.5.1 - Reasonable and Necessary Provisions in LCDs

Specific Therapy Policies. Sections 220 and 230 of this chapter describe the standards and conditions that apply generally to outpatient rehabilitation therapy services. Specific policies may differ by setting. Other policies concerning therapy services are found in other manuals. When a therapy service policy is specific to a setting, it takes precedence over these general outpatient policies. For special rules on:

- *CORFs - See chapter 12 of this manual and also Pub. 100-04, chapter 5;*
- *SNF - See chapter 8 of this manual and also Pub. 100-04, chapter 6, for SNF claims/billing;*
- *HHA - See chapter 7 of this manual, and Pub. 100-04, chapter 10;*
- *GROUP THERAPY AND STUDENTS - See Pub.100-04, chapter 5, §100.10;*
- *ARRANGEMENTS - Pub. 100-01, chapter 5, §10.3;*
- *COVERAGE is described in the Medicare Program Integrity Manual, Pub. 100-08, chapter 13, §13.5.1; and*

THERAPY CAPS - See Pub. 100-04, chapter 5, §10.2, for a complete description of this financial limitation.

C - General

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

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

Where a prospective payment system (PPS) applies, therapy services are paid when services conform to the requirements of that PPS. For example, see Pub. 100-04 for a description of applicable Inpatient Hospital Part B and Outpatient PPS rules. Reimbursement for therapy provided to Part A inpatients of hospitals or residents of SNFs in covered stays is included in the respective PPS rates.

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

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

220.1 - Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

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, the Medicare National Coverage Determinations Manual.

Other payment rules are found in Pub. 100-04, 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 of coverage apply. The requirements noted (*) are also conditions of payment in 42CFR424.24(c) and according to the Act §1835 (a)(2)(D) are the three conditions that must be certified:

- *(i) such services are or were required because the individual needed therapy services* (see §220.1.3); and*
- *(ii) 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 §220.1.2); and*
- *(iii) such services are or were furnished while the individual is or was under the care of a physician* (see §220.1.1); and*
- *Services must be furnished on an outpatient basis. (See §220.1.4)*

All of the conditions are met when a physician/NPP certifies an outpatient plan of care for therapy. Certification is required for coverage and payment of a therapy claim. Each of these conditions is discussed separately in the sections that follow.

220.1.1 - Outpatient Therapy Must be Under the Care of a Physician/Nonphysician Practitioners (NPP) (Orders/Referrals and Need for Care)

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

An order (sometimes called a referral) for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician. However, the certification requirements are met when the

physician certifies the plan of care. If the signed order includes a plan of care (see essential requirements of plan in §220.1.2), no further certification of the plan is required. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.

(The CORF services benefit does not recognize an NPP for orders and certification.)

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

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

Reference: 42CFR 410.61

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

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

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

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

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

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

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

Therapy may be initiated by qualified professionals or qualified personnel based on a dictated plan after it has been committed to writing and before it is signed. A dictated plan must be signed by close of business on the day following dictation by the person who established it.

Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same qualified professional who establishes the plan and

that plan is established and signed by close of business on the next day by the same qualified professional. Payment for services provided before a plan is established may be denied.

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

The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24 and 410.61):

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

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 qualified physical therapist (in the case of physical therapy);*
- *The qualified speech-language pathologist (in the case of speech-language pathology services);*
- *The qualified 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 would be a significant change. An insignificant alteration in the plan would be a decrease 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. Only when the patient's condition changes significantly, making revision of long term goals necessary, is a physician's/NPP's signature required on the change, (long term goal changes may be accompanied by changes to procedures and modalities).

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

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

Reference: 42CFR424.24(c)

See specific certification rules for CORF in this manual, chapter 12, §30(E) and in Pub. 100-01, chapter 4, §20 for hospital services.

A - Method and Disposition of Certifications

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

The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility and/or practitioner. Acceptable documentation of certification may be, for example, a physician's progress note, a physician/NPP order, or a plan of care that is signed and dated during the interval of treatment by a physician/NPP, and indicates the physician/NPP is aware that therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan when there is evidence the plan was sent (e.g., to the office) or is available in the record (e.g., of the institution that employs the physician/NPP) for the physician/NPP to review.

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

B - Initial Certification of Plan

The physician's/NPP's certification of the plan for the first 30 days of treatment (with or without an order) satisfies all of the certification requirements noted above in §220.1 for the first interval of 30 calendar days or 1 month of treatment.

Timing of Initial Certification. The provider or supplier (e.g., facility, physician/NPP, or therapist) should obtain certification as soon as possible after the plan of care is established, unless the requirements of delayed certification are met. "As soon as possible" means that the physician/NPP shall certify the plan as soon as it is obtained, or before the end of the first interval beginning at the initial therapy treatment. Since payment may be denied if a physician does not certify the plan, the therapist should forward the plan to the physician as soon as it is established. Evidence of diligence in providing the plan to the physician may be considered by the contractor during review in the event of a delayed certification.

Timely certification of the first interval of treatment is met when physician/NPP certification of the plan for the first interval of treatment is documented, by signature or verbal order, and dated before the end of the interval. If the order to certify is verbal, it must be followed within 14 days by a signature to be timely. A dated notation of the order to certify the plan should be made in the patient's medical record.

C - Review of Plan and Recertification

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

Payment and coverage conditions require that the plan must be reviewed, dated and signed by a physician/NPP every 30 days to complete the certification requirements in 42CFR 410.61(e), unless delayed certification requirements are met. When therapy services are continued for longer than 1 month, the physician/NPP who is responsible for the patient's care at that time should review and certify the plan for each interval of therapy. It is not required that the same physician/NPP order, certify and/or recertify the plans.

Recertifications that document the need for continued therapy in subsequent intervals should be signed before or during the subsequent intervals of treatment (when they are timely) or later, when they are delayed. Subsequent recertifications should be completed before or during the next interval, unless they are delayed.

Physician/NPP options for Certification. A physician/NPP may certify or recertify a plan for less than 30 days of treatment, if the physician/NPP determines it is appropriate. This direction should be included in an order preceding the treatment (preferably), or in the plan of care.

Physicians/NPPs may require that the patient make a visit for an examination if, in the professional's judgment, the visit is needed prior to certifying the plan. Physicians/NPPs should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care. Physicians/NPPs should not sign a certification if they require a visit and a visit was not made. However, Medicare does not require a visit unless the National Coverage Determination (NCD) for a particular treatment requires it (e.g., see Pub. 100-03, §270.1 - Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds).

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

D - Delayed Certification

References: §1835(a) of the Act

42CFR424.11(d)(3)

Certifications are required for each 30 day interval of treatment and are timely when the certification occurs before or during the interval. Certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable

without justification for 30 days after they are due. Delayed certification should include one or more certifications or recertifications on a single signed and dated document.

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

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

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

Example Payment should not be denied, even when certified 2 years after treatment, when there is evidence that a physician approved needed treatment, such as an order, documentation of therapist/physician/NPP discussion of the plan, chart notes, meeting notes, requests for certification, or certifications for intervals before or after the service in question.

E - Denials Due to Certification

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

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

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

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

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

220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

Reference: 42CFR410.60

Therapy services are payable under the Physician Fee Schedule when furnished by 1.) a provider to its outpatients in the patient's home; 2.) a provider to patients who come to the facility's outpatient department; 3.) a provider to inpatients of other institutions, or 4.) a supplier to patients in the office or in the patient's home. (CORF rules differ on providing therapy at home.)

Coverage includes therapy services furnished by participating hospitals and SNFs to their inpatients who have exhausted Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of therapy services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered therapy services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of therapy services may furnish such services to inpatients of another health facility.

A certified distinct part of an institution is considered to be a separate institution from a nonparticipating part of the institution. Consequently, the certified distinct part may render covered therapy services to the inpatients of the noncertified part of the institution or to outpatients. The certified part must bill the intermediary under Part B.

Therapy services are payable when furnished in the home at the same physician fee schedule payments as in other outpatient settings. Additional expenses incurred by providers due to travel to a person who is not homebound will not be covered.

Under the Medicare law, there is no authority to require a provider to furnish a type of service. Therefore, a hospital or SNF may furnish therapy to its inpatients without having to set up facilities and procedures for furnishing those services to its outpatients. However, if the provider chooses to furnish a particular service, it may not charge any individual or other person for items or services for which the individual is entitled to have payment made under the program because it is bound by its agreement with Medicare. Thus, whenever a hospital or SNF furnishes outpatient therapy to a Medicare beneficiary (either directly or under arrangements with others) it must bill the program under Part B and may charge the patient only for the applicable deductible and coinsurance.

220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

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. Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed. These services are not covered because they do not involve complex and sophisticated therapy procedures, or the judgment and skill of a qualified therapist for safety and effectiveness.

Services which do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions for 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 are provided by staff who are not qualified or appropriately supervised, are not covered or 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.

B - Reasonable and Necessary

To be considered reasonable and necessary the following conditions must each be met:

- *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 qualified therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a qualified 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.*

- *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, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being 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.*
- *The skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program as described below.*
- *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 should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See item C for descriptions of skilled (rehabilitative) services.*
- *There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance 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 are excluded by §1862(a)(1) of the Act and are thus subject to consideration under the waiver of liability provision in §1879 of the Act.*

C - Rehabilitative Therapy

Covered therapy services shall be rehabilitative therapy services unless they meet the criteria for maintenance therapy requiring the skills of a therapist described below. Rehabilitative therapy services are skilled procedures that may include but are not limited to:

- *Evaluations; 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*
- *Patient and family training to augment rehabilitative treatment or establish a maintenance program. Education of staff and family should be ongoing through treatment and instructions may have to be modified intermittently if the patient's status changes.*

Rehabilitative therapy occurs when the skills of a therapist (as defined by the scope of practice for therapists in the state), are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. Rehabilitative therapy services are reasonable and necessary services furnished by or under the supervision of qualified professionals.

Skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic 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. In the case of a progressive degenerative disease, for example, service may be intermittently necessary to determine the need for assistive equipment and establish a program to maximize function. 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 without the supervision of qualified professionals.

If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, therapy would not be covered because it is not considered rehabilitative or reasonable and necessary.

Services that can be safely and effectively furnished by nonskilled personnel without the supervision of qualified professionals are not rehabilitative therapy services. If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, or does not legitimately require the services of a qualified professional for management of a maintenance program as described below, the services will no longer be considered reasonable and necessary. Services that are not reasonable or necessary should be excluded from coverage under §1862(a)(1) of the Act.

Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery) which 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. (See exceptions for maintenance in §220.2D of this manual).

D - Maintenance Programs

During the last visits for rehabilitative treatment, the qualified professional may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized knowledge and judgment of a qualified therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.

Where a maintenance program is not established until after the rehabilitative physical therapy program has been completed (and the skills of a therapist are not necessary) development of a maintenance program would not be considered reasonable and necessary for the treatment of the patient's condition. It would be excluded from coverage under §1862(a)(1) of the Act unless the patient's safety was at risk (see below).

Example. A Parkinson patient who has been under a rehabilitative physical therapy program may require the services of a therapist during the last week or two of treatment to determine what type of exercises will contribute the most to maintain the patient's present functional level following cessation of treatment. In such situations, the design 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 infrequent reevaluations as may be required would constitute covered therapy because of the need for the skills of a qualified professional.

Evaluation and Maintenance Plan without Rehabilitative Treatment. After the initial evaluation of the extent of the disorder, illness, or injury, if the treating qualified professional determines the potential for rehabilitation is insignificant, an appropriate maintenance program may be established prior to discharge. Since the skills of a therapist are required for the development of the maintenance program and training the patient or caregivers, this service is covered.

Example. The skills of a qualified speech-language pathologist may be covered to develop a maintenance program for a patient with multiple sclerosis, for services intended to prevent or minimize deterioration in communication ability caused by the medical condition, when the patient's current medical condition does not yet justify the need for the skilled services of a speech-language pathologist. Evaluation, development of the program and training the family or support personnel would require the skills of a therapist and would be covered. The skills of a therapist are not required and services are not covered to carry out the program.

Skilled Maintenance Therapy for Safety. If the services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may be necessary for the safe and effective delivery of such services. When

the patient's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

Example. Where there is an unhealed, unstable fracture, which requires regular exercise to maintain function until the fracture heals, the skills of a therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

230 - Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

230.1 - Practice of Physical Therapy

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

A - General

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

B - Qualified Physical Therapist Defined

Reference: 42CFR484.4

A qualified physical therapist for program coverage purposes is a person who is licensed as a physical therapist by the state in which he or she is practicing and meets one of the following requirements:

- *Has graduated from a physical therapy curriculum approved by (1) the American Physical Therapy Association, or by (2) the Committee on Allied Health Education and Accreditation of the American Medical Association, or (3) Council on Medical Education of the American Medical Association, and the American Physical Therapy Association; or*
- *Prior to January 1, 1966, (1) was admitted to membership by the American Physical Therapy Association, or (2) was admitted to registration by the American Registry of Physical Therapists, or (3) has graduated from a physical therapy curriculum in a 4-year college or university approved by a state department of education; or*
- *Has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking qualification as a physical therapist after December 31, 1977; or*
- *Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy; or*
- *If trained outside the United States, (1) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for*

Physical Therapy, (2) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

C - Services of Physical Therapy Support Personnel

Reference: 42CFR 484.4

A physical therapist assistant (PTA) is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and

- *Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or*
- *Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a PTA after December 31, 1977.*

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

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

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

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

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

D- Application of Medicare Guidelines to PT Services

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

230.2 - Practice of Occupational Therapy

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

A - General

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

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

- *The evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;*
- *The selection and teaching of task-oriented therapeutic activities designed to restore physical function; e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns;*
- *The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness; e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient;*
- *The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function; e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image;*
- *The teaching of compensatory technique to improve the level of independence in the activities of daily living, for example:*
    - *Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand;*
    - *Teaching an upper extremity amputee how to functionally utilize a prosthesis;*
    - *Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities as independently as possible; or*

- *Teaching a patient with a hip fracture/hip replacement techniques of standing tolerance and balance to enable the patient to perform such functional activities as dressing and homemaking tasks.*

- *The designing, fabricating, and fitting of orthotics and self-help devices; e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed independently; or*
- *Vocational and prevocational assessment and training, subject to the limitations specified in item B below.*

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

B - Qualified Occupational Therapist Defined

Reference: 42CFR484.4

A qualified occupational therapist for program coverage purposes is an individual who meets one of the following requirements:

- *Is a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education of the American Medical Association and the American Occupational Therapy Association;*
- *Is eligible for the National Registration Examination of the American Occupational Therapy Association; or*
- *Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapist after December 31, 1977.*

C - Services of Occupational Therapy Support Personnel

Reference: 42CFR 484.4

An occupational therapy assistant (OTA) is a person who:

- *Meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association; or*
- *Has 2 years of appropriate experience as an occupational therapy assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977.*

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

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

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

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

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

D - Application of Medicare Guidelines to Occupational Therapy Services

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

Occupational therapy may include vocational and prevocational assessment and training. When services provided by an occupational therapist are related solely to specific employment opportunities, work skills, or work settings, they are not reasonable

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

230.3 - Practice of Speech-Language Pathology

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

A - General

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

B - Qualified Speech-Language Pathologist Defined

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

- *The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology or audiology) granted by the American Speech-Language Hearing Association; or*
- *Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.*

Speech-language pathologists may not enroll and submit claims directly to Medicare. The services of speech-language pathologists may be billed by providers such as rehabilitation agencies, HHAs, CORFs, hospices, outpatient departments of hospitals, and suppliers such as physicians, NPPs, physical and occupational therapists in private practice.

C - Services of Speech-Language Pathology Support Personnel

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

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

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

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

1 - Evaluation Services

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

2 - Therapeutic Services

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

- *Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;*
- *Neurological disease such as Parkinsonism or Multiple Sclerosis with dysarthria, dysphagia, inadequate respiratory volume/control, or voice disorder; or*
- *Laryngeal carcinoma requiring laryngectomy resulting in aphonia.*

3 - Aural Rehabilitation

Aural rehabilitation may be covered and medically necessary when it has been determined by a speech-language pathologist in collaboration with an audiologist that the beneficiary's current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient's functional communication needs.

Assessment for the need for aural rehabilitation may be done by a speech language pathologist and includes evaluation of comprehension and production of language in oral, signed or written modalities, speech and voice production, listening skills, speech reading, communications strategies, and the impact of the hearing loss on the patient/client and family.

Aural rehabilitation consists of treatment that focuses on comprehension, and production of language in oral, signed or written modalities; speech and voice production, auditory training, speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training, communication strategies, education and counseling. In

determining the necessity for treatment, the beneficiary's performance in both clinical and natural environment should be considered.

4 - Dysphagia

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

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

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

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

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

A - General

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

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

Private practice also includes therapists who are practicing therapy as employees of another supplier, of a professional corporation or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of an institutional provider.

Services should be furnished in the therapist's or group's office or in the patient's home. The office is defined as the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in the practice at that location. If services are furnished in a private practice office space, that space shall be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. For example, a therapist in private practice may furnish aquatic therapy in a community center pool. As required in other settings (such as rehabilitation agencies and CORFs), the practice would have to rent or lease the pool for those hours, and the use of the pool during that time would have to be restricted to the therapist's patients, in order to recognize the pool as part of the therapist's own practice office during those hours. Therapists in private practice must be approved as meeting certain requirements, but do not execute a formal provider agreement with the Secretary.

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

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

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

B - Private Practice Defined

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

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

The therapist need not be in full-time private practice but must be engaged in private practice on a regular basis; i.e., the therapist is recognized as a private practitioner and

for that purpose has access to the necessary equipment to provide an adequate program of therapy.

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

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

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

C - Assignment

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

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

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

If physicians/NPPs, PTPPs or OTPPs accept assignment (are participating), they must accept the Medicare Physician Fee Schedule amount as payment. Medicare pays 80% and the patient is responsible for 20%. In contrast, if they do not accept assignment, Medicare will only pay 95% of the fee schedule amount. However, when these services are not furnished on an assignment-related basis, the limiting charge applies. (See §1848(g)(2)(c) of the Act.)

***NOTE**: Services furnished by a therapist in the therapist's office under arrangements with hospitals in rural communities and public health agencies (or services provided in*

the beneficiary's home under arrangements with a provider of outpatient physical or occupational therapy services) are not covered under this provision. See section 230.6.

230.5 - Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Nonphysician Practitioners (NPP)

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

References: §1861(s)(2)(A) of the Act

42 CFR 410.10(b)

42 CFR 410.26

Pub. 100-02, ch. 15, § 60.

The Benefit. Therapy services have their own benefit under §1861 of the Social Security Act and shall be covered when provided according to the standards and conditions of the benefit described in Medicare manuals. The statute 1862(a)(20) requires that payment be made for a therapy service billed by a physician/NPP only if the service meets the standards and conditions--other than licensing--that would apply to a therapist. (For example, see coverage requirements in Pub. 100-08, chapter 13, §13.5.1(C), Pub. 100-04, chapter 5, and also the requirements of this manual, §220 and §230.

Incident to a Therapist. There is no coverage for services provided incident to the services of a therapist. Although PTAs and OTAs work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services incident to a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist's service.

Qualifications of Auxiliary Personnel. Therapy services appropriately billed incident to a physician's/NPP's service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting with one exception. When therapy services are performed incident to a physician's/NPP's service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. Qualifications for therapists are found in 42CFR484.4 and in section 230.1, 230.2, and 230.3 of this manual. In effect, these rules require that the person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above. Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

The services of PTAs and OTAs also may not be billed incident to a physician's/NPP's service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, when directly supervised by the PT or the

services of the OTA, when directly supervised by the OT may be billed by the physician group as PT or OT services using the PIN/NPI of the enrolled PT (or OT). (See Section 230.4 for private practice rules on billing services performed in a physician's office.) If the PT or OT is not enrolled, Medicare shall not pay for the services of a PTA or OTA billed incident to the physician's service, because they do not meet the qualification standards in 42CFR484.4.

Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements in this manual in chapter 15, §60. Where the policies have different requirements, the more stringent requirement shall be met.

For example, when therapy services are billed as incident to a physician/NPP services, the requirement for direct supervision by the physician/NPP and other incident to requirements must be met, even though the service is provided by a licensed therapist who may perform the services unsupervised in other settings.

The mandatory assignment provision does not apply to therapy services furnished by a physician/NPP or "incident to" a physician's/NPP's service. However, when these services are not furnished on an assignment-related basis; the limiting charge applies.

For emphasis, following are some of the standards that apply to therapy services billed incident-to the services of a physician/NPP in the physician's/NPP's office or the beneficiary's residence.

A. *Therapy services provided to the beneficiary must be covered and payable outpatient rehabilitation services as described, for example, in this section as well as Pub. 100-08, chapter 13, §13.5.1.*

B. *Therapy services must be provided by, or under the direct supervision of a physician (a doctor of medicine or osteopathy) or NPP who is legally authorized to practice therapy services by the state in which he or she performs such function or action. Direct supervision requirements are the same as in 42CFR410.32(b)(3). The supervisor must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician/NPP must be present in the same room in the office where the service is performed.*

C. *The services must be of a level of complexity that require that they be performed by a therapist or under the direct supervision of the therapist, physician/NPP who is licensed to perform them. Services that do not require the performance or supervision of the therapist, physician/NPP, are not considered reasonable or necessary therapy services even if they are performed or supervised by a physician/NPP or other qualified professional.*

D. *Services must be furnished under a plan of treatment as in §220.1.2 of this chapter. The services provided must relate directly to the physician/NPP service to which it is incident.*

230.6 - Therapy Services Furnished Under Arrangements With Providers and Clinics

(Rev.36 , Issued:06-24 -05, Effective: 06-06-05, Implementation: 06-06-05)

References: See also Pub. 100-01, chapter 5, §10.3.

A - General

For rules regarding services provided under arrangement, see Pub. 100-01, chapter 5, §10.3.

A provider may have others furnish outpatient therapy (physical therapy, occupational therapy, or speech-language pathology) services through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service.

However, it is not intended that the provider merely serve as a billing mechanism for the other party. For such services to be covered the provider must assume professional responsibility for the services.

The provider's professional supervision over the services requires application of many of the same controls that are applied to services furnished by salaried employees. The provider must:

- *Accept the patient for treatment in accordance with its admission policies;*
- *Maintain a complete and timely clinical record on the patient which includes diagnosis, medical history, orders, and progress notes relating to all services received;*
- *Maintain liaison with the attending physician/NPP with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by the physician/NPP;*
- *Secure from the physician/NPP the required certifications and recertifications; and*
- *Ensure that the medical necessity of such service is reviewed on a sample basis by the agency's staff or an outside review group.*

In addition, when a provider provides outpatient services under an arrangement with others, such services must be furnished in accordance with the terms of a written contract, which provides for retention by the provider of responsibility for and control and supervision of such services. The terms of the contract should include at least the following:

- *Provide that the therapy services are to be furnished in accordance with the plan of care established according to Medicare policies for therapy plans of care in Section 220.1.2 of this chapter;*
- *Specify the geographical areas in which the services are to be furnished;*

- *Provide that contracted personnel and services meet the same requirements as those which would be applicable if the personnel and services were furnished directly by the provider;*
- *Provide that the therapist will participate in conferences required to coordinate the care of an individual patient;*
- *Provide for the preparation of treatment records, with progress notes and observations, and for the prompt incorporation of such into the clinical records of the clinic;*
- *Specify the financial arrangements. The contracting organization or individual may not bill the patient or the health insurance program; and*
- *Specify the period of time the contract is to be in effect and the manner of termination or renewal.*

B - Special Rules for Hospitals

- *A hospital may bill Medicare for outpatient therapy (physical therapy, occupational therapy, or speech-language pathology) services that it furnishes to its outpatients either directly or under arrangements in the hospital's outpatient department. If a hospital furnishes medically necessary therapy services in its outpatient department to individuals who are registered as its outpatients, those services must be billed directly by the hospital using bill type 13X or 85X for critical access hospitals. Note that services provided to residents of a Medicare-certified SNF may not be billed by the hospital as services to its outpatients.*
- *When a hospital sends its therapists to the home of an individual who is registered as an outpatient of the hospital but who is unable, for medical reasons, to come to the hospital to receive medically necessary therapy services, the services must meet the requirements applicable to outpatient hospital therapy services, as set forth in the regulations and applicable Medicare manuals. The hospital may bill for those services directly using bill type 13X or 85X for critical access hospitals.*
- *If a hospital sends its therapists to provide therapy services to individuals who are registered as its outpatients and who are residing in the non-certified part of a SNF, or in another residential setting (e.g., a group home, assisted living facility or domiciliary care home), the hospital may bill for the services as hospital outpatient services if the services meet the requirements applicable to outpatient hospital therapy services, as set forth in the regulations and applicable Medicare manuals.*
- *A hospital may make an arrangement with another entity such as an Outpatient Rehab Facility (Rehabilitation Agency) or a private practice, to provide therapy services to individuals who are registered as outpatients of the hospital. These services must meet the requirements applicable to services furnished under arrangements and the requirements applicable to the outpatient hospital therapy services as set forth in the regulations and applicable Medicare manuals. The hospital uses bill type 13X or 85X for*

critical access hospitals to bill for the services that another entity furnishes under arrangement to its outpatients.

- *Where the provider is a public health agency or a hospital in a rural community, it may enter into arrangements to have outpatient physical therapy services furnished in the private office of a qualified physical therapist if the agency or hospital does not have the capacity to provide on its premises all of the modalities of treatment, tests, and measurements that are included in an adequate outpatient physical therapy program and the services and modalities which the public health agency or hospital cannot provide on its premises are not available on an outpatient basis in another accessible certified facility.*
- *In certain settings and under certain circumstances, hospitals may not bill Medicare for therapy services as services of the hospital:*
  - *If a hospital sends its therapists to provide therapy services to patients of another hospital, including a patient at an inpatient rehabilitation facility or a long term care facility, the services must be furnished under arrangements made with the hospital sending the therapists by the hospital having the patients and billed as hospital services by the facility whose patients are treated. These services would be subject to existing hospital bundling rules and would be paid under the payment method applicable to the hospital at which the individuals are patients.*
  - *A hospital may not send its therapists to provide therapy services to individuals who are receiving services from an HHA under a home health plan of care and bill for the therapy services as hospital outpatient services. For patients under a home health plan of care, payment for therapy services (unless provided by physicians/NPPs) is included or bundled into Medicare's episodic payment to the HHA, and those services must be billed by the HHA under the HHA consolidated billing rules. For patients receiving HHA services under an HHA plan of care, therapy services must be furnished directly or under arrangements made by the HHA, and only the HHA may bill for those services.*
  - *If a hospital sends its therapists to provide services under arrangements made by a SNF to residents of the Medicare-certified part of a SNF, SNF consolidated billing rules apply. For arrangements specific to SNF Part A, see Pub. 100-04, chapter 6, §10.4. This means that therapy services furnished to SNF residents in the Medicare-certified part of a SNF cannot be billed by any entity other than the SNF. Therefore, a hospital may not bill Medicare for PT/OT/SLP services furnished to residents of a Medicare-certified part of a SNF by its therapists as services of the hospital.*

    ***NOTE**: If the SNF resident is in a covered Part A stay, the therapy services would be included in the SNF's global PPS per diem payment for the covered Part A stay itself. If the resident is in a noncovered stay (Part A benefits exhausted, no prior qualifying hospital stay, etc.), but remains*

in the Medicare-certified part of a SNF, the SNF would submit the Part B therapy bill to its fiscal intermediary.

SNF Setting	***Applicable Rules***	
Medicare Part A or B	***Consolidated Billing Rules Apply?***	***Hospital May Bill For Outpatient Services?***
Part A (Medicare Covered / PPS) Resident in Medicare-certified part of a SNF	*Yes*	*No*
Medicare Part B Resident in Medicare-certified part of a SNF	*Yes*	*No*
Medicare Part B *Not a Resident in Medicare-certified part of a SNF*	*No*	*Yes*

- *A hospital may not send therapy staff to provide therapy services in non-residential health care settings and bill for the services as if they were provided at the hospital, even if the hospital owns the other facility or entity. Examples of such non-residential settings include CORFs, rehabilitation agencies, ORFs and offices of physicians/NPPs or other practitioners, such as physical therapists. For example, services furnished to patients of a CORF must be billed as CORF services and not as outpatient hospital services. Even if a CORF contracts with a hospital to furnish services to CORF patients, the hospital may not bill Medicare for the services as hospital outpatient services. However, the CORF could have the hospital furnish services to its patients under arrangements, in which case the CORF would bill for the services.*

Psychiatric hospitals are treated the same as other hospitals for the purpose of therapy billing.