

PART B



Physical, Occupational & Speech Therapy Billing Guide July 2010

NHIC, Corp.

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Table of Contents

Introduction	5
GENERAL INFORMATION	6
Definition of Terms.....	6
Reasonable and Necessary.....	11
Financial Limitation	11
Exceptions to the Therapy Cap	12
Qualifications	21
Physical Therapist	21
Physical Therapy Assistant (PTA)	22
Occupational Therapist.....	23
Occupational Therapy Assistant (OTA)	24
Speech-Language Pathology	25
Services provided incident to	29
therapy Assistants as Clinical Instructors	29
Therapy Students	29
Support Personnel and Supplies	31
Aides.....	31
Supplies.....	31
Private Practice	31
Therapy Provided by Physicians and Physician Employees	32
Conditions for Coverage of Outpatient Physical Therapy and Occupational	
Therapy	34
Plan of Care for Outpatient Physical Therapy AND OCCUPATIONAL Therapy	35
Establishing the Plan	35
Treatment under a Plan	35
Two Plans.....	35
Contents of Plan	36
Changes to the Therapy Plan	38
Certification and Recertification of Need for Treatment and therapy plans of care	39
Initial Certification	40
Timing of Initial Certification.....	40
Review of Plan and Recertification	40
Physician /NPP Options for Certification.....	41
Restrictions on Certification	41
Delayed Certification.....	41
Denials Due to Certification	42
Documentation Requirements for Therapy Services	43
Evaluation/Re-Evaluation and Plan of Care.....	46
Requirement That Services Be Furnished on an Outpatient Basis	58
Reasonable and Necessary Outpatient Rehabilitation Therapy Services	58
General.....	58
Reasonable and Necessary.....	59
Rehabilitative Therapy	60

Physical, Occupational & Speech Therapy Billing Guide

Maintenance Programs.....	61
Evaluation and Maintenance Plan without Rehabilitative Treatment	61
Skilled Maintenance Therapy for Safety	61
Practice of Occupational Therapy	62
Additional Services	63
Hot Pack, Hydrocollator, Infra-Red Treatment, Paraffin Baths and Whirlpool Baths .	63
Hot/Cold Packs.....	63
Gait Training 97116	63
Ultrasound, Shortwave, and Microwave Diathermy Treatment.....	63
Assessment.....	63
Range of Motion Tests.....	64
Therapeutic Exercises 97110	64
Canalith Repositioning 97112.....	64
Group Therapy Services 97150.....	64
Biofeedback Therapy.....	64
Biofeedback Therapy for the Treatment of Urinary Incontinence.....	65
Wound Care Provided Within Scope of State Practice Acts	65
Vertebral Axial Decompression (VAX-D)	65
Billing and Coding Guidelines	66
Place of Service.....	66
Evaluation/Reevaluation	67
Modifiers	68
Reporting of Service Units	70
Determining What Time Counts Towards 15-Minute Timed Codes.....	71
Prospective Payment System (PPS).....	72
Home Health Claims.....	72
Skilled Nursing Facility Consolidated Billing	72
National Correct Coding Initiative.....	73
Medically Unlikely Edits.....	73
Limitation of Liability (Advance Beneficiary Notice).....	73
ABN Modifiers.....	74
Local Coverage Determination (LCD).....	74
National Coverage Determination (NCD).....	74
Medicare Fraud and Abuse	75
Recovery Audit Contractor.....	76
Telephone and Address Directory	77
Provider Interactive Voice Response (IVR) Directory	77
Provider Customer Service Directory.....	77
Mailing Address Directory	78
Internet Resources.....	80
NHIC, Corp.	80
Medicare Coverage Database	80
Medicare Learning Network.....	81
Open Door Forums	81
Publications and Forms	81

Physical, Occupational & Speech Therapy Billing Guide

Revision History.....	82
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INTRODUCTION

The Provider Education and Outreach Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Physical and Occupational Therapy billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), *Medicare B Resource* (quarterly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-2, Chapter 7 and Chapter 15; Publication 100-4, Chapter 5 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.hhs.gov/manuals/>

If you have questions or comments regarding this material, please call the appropriate NHIC Customer Service Center for your state. The telephone numbers are listed at the end of this guide.

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GENERAL INFORMATION

Physical therapy and occupational therapy are defined as services prescribed by a physician or non-physician practitioner within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified physical or occupational therapist. For services to be covered they must not be excluded and they must be reasonable and necessary skilled therapy services. This guide includes an extensive discussion of the conditions that must be met for the services to be considered “reasonable and necessary”.

Definition of Terms

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

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

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

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

COMPLEXITIES are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses (ICD-9 codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

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

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

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

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

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

INTERVAL of *certified* treatment (certification interval) consists of 90 calendar days or less, based on an individual's needs. A physician/NPP may certify a plan of care for an interval length

Physical, Occupational & Speech Therapy Billing Guide

that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report period.

Physical, Occupational & Speech Therapy Billing Guide

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

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

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

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

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies.

Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants are limited in the services they may provide (see section 230.1 and 230.2) and may not supervise others.

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

SIGNATURE means a legible identifier of any type *acceptable according to policies* in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.4.1.1 (B) concerning signatures.

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

Physical, Occupational & Speech Therapy Billing Guide

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

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

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

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

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

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

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

Reasonable and Necessary

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

- The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition;
- The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified Physical Therapist (PT) or Occupational Therapist (OT) or under the therapist's supervision. Services which do not require the performance or supervision of the therapist are not considered reasonable or necessary PT or OT services, even if they are performed or supervised by a therapist.

NOTE: See additional information under "Reasonable and Necessary Outpatient Rehabilitation Therapy Services".

Financial Limitation

Financial limitations on outpatient therapy services began for therapy services rendered on or after January 1, 2006. The limits were \$1840 in 2009. For 2010, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1860; the limit for occupational therapy is \$1860. Limits apply to outpatient Part B therapy services from all settings except outpatient hospital (place of service code 22 on carrier claims) and hospital emergency room (place of service code 23 on carrier claims).

Contractors apply the financial limitations to the Medicare Physician Fee Schedule (MPFS) amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

Providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless the outpatient care is furnished directly or under arrangements by a hospital. It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and that, where necessary, appropriate care above the limits can be obtained at a hospital outpatient therapy department. Providers/suppliers may use the Advance Beneficiary Notice of Noncoverage (ABN, Form CMS-R-131) form, or a similar form of their own design to inform beneficiaries of the therapy financial limitation.

When using the ABN form as a voluntary notice, the form requirements specified for its mandatory use do not apply. The beneficiary should not be asked to choose an option or sign the form. The provider should include the beneficiary's name on the form and the reason that Medicare may not pay in the space provided within the form's table. Insertion of the following reason is suggested:

"Services do not qualify for exception to therapy caps. Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap and the year or the dates of service to which it applies, e.g., \$1860 in 2010) unless the beneficiary qualifies for a cap exception." Providers *are to* supply this same information for occupational therapy services

Physical, Occupational & Speech Therapy Billing Guide

over the limit for the same time period, if appropriate. A cost estimate for the services may be included but is not required.

After the cap is exceeded, voluntary notice via a provider's own form or the ABN is appropriate even when services are excepted from the cap. The ABN is also used **BEFORE** the cap is exceeded when notice about noncovered services is mandatory. For example, whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements, an ABN must be issued before the beneficiary receives that service. At the time the clinician determines that skilled services are not necessary, the clinical goals have been met, or that there is no longer potential for the rehabilitation of health and/or function in a reasonable time, the beneficiary should be informed. If the beneficiary requests further services, inform the beneficiary that Medicare most likely will not provide additional coverage, and issue the ABN prior to delivering any services. The ABN informs the beneficiary of his/her potential financial obligation to the provider and provides guidance regarding appeal rights. When the ABN is used as a mandatory notice, providers must adhere to the form requirements set forth in chapter 30, section 50.6.3.

The ABN can be found at: <http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip>

Exceptions to the Therapy Cap

The Deficit Reduction Act of 2006 directed CMS to develop a process to allow for *exceptions* to the caps in cases where continued therapy services are medically necessary.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. For example, if a beneficiary is being treated for a condition that does not qualify for an exception, should a change in status result in the beneficiary satisfying the requirements for a cap exception, the provider or supplier would utilize the modifier for automatic process exceptions.

In 2006, Exception Processes fell into two categories, Automatic Process Exceptions, and Manual Process Exceptions. Beginning January 1, 2007, there is no manual process for exceptions. All services that require exceptions to caps shall be processed using the automatic process. All requests for exception are in the form of a KX modifier added to claim lines. The KX modifier is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. One provision of this legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008.

The exception process allows for automatic exceptions to caps for medically necessary services:

Automatic Process Exception: An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

Physical, Occupational & Speech Therapy Billing Guide

No specific documentation is submitted to the contractor for automatic process exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the automatic process exception when documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the automatic process exception, clinicians shall consider, for example, whether services are appropriate to:

- The patient's condition including the diagnosis, complexities and
- The services provided including their type, frequency and intensity;
- The interaction of current active conditions and complexities that directly and significantly influence treatment such that it causes services to exceed caps.

In addition, the following should be considered before using the automatic exception process:

Exceptions

Evaluation - (92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, and 97004) CMS will accept therapy evaluation procedures from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services.

Exceptions for Conditions or Complexities Identified by ICD-9-CM codes

Clinicians may utilize the automatic process for exception for any diagnosis for which they can justify services exceeding the cap. Based upon analysis of claims data, research and evidence based practice guidelines, CMS has identified conditions and complexities represented by ICD-9-CM codes. (See list provided below.) Except in very rare circumstances, one or more of these diagnoses will be appropriate for patients who require therapy services that exceed therapy caps. Clinicians may use the automatic process of exception for beneficiaries who do not have a condition or complexity on this list; however, they must justify carefully the provision of a therapy service that exceeds caps for that patient's condition.

NOT ALL patients who have a condition or complexity on the list are "automatically" accepted from therapy caps. Contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical.

Regardless of the condition, the patient must also meet other requirements for coverage. For example, the patient must require skilled treatment for a covered, medically necessary service; the services must be appropriate in type, frequency and duration for the patient's condition and service must be documented appropriately. Guidelines for utilization of therapy services may be found in Medicare manuals, Local Coverage Determinations of Medicare contractors, and professional guidelines issued by associations and states.

Bill the most relevant diagnosis. As always, when billing for therapy services, the ICD-9-CM code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason. For example, when a patient with diabetes is being treated for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors Local Coverage Determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy code in the primary position. In that case, the relevant code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

When a patient's condition is the reason for the exception, that condition must be related to the therapy goals and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Codes marked as complexities represented by ICD-9-CM codes on the list below are unlikely to require therapy services that would exceed the caps unless they occur in a patient who also has another condition (either listed or not listed). Therefore, documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition. For example, if the condition underlying the reason for therapy is V43.64, hip replacement, the treatment may have a goal to ambulate 60 feet with stand-by assistance and a KX modifier may be appropriate for gait training (assuming the severity of the patient is such that the services exceed the cap). Alternatively, it would not be appropriate to use the KX modifier for a patient who recovered

Physical, Occupational & Speech Therapy Billing Guide

from hip replacement last year and is being treated this year for a sprain that is not represented on the list as an exception and for which extensive therapy exceeding caps is not justified.

Physical, Occupational & Speech Therapy Billing Guide

DO NOT USE ICD-9-CM codes that do not describe a specific underlying condition or specific body part(s) affected that resulted in the current therapy episode of care. In order to qualify the beneficiary for use of the automatic process for exception, the condition or complexity must directly and significantly affect the type, frequency, intensity and/or duration of required, medically necessary, skilled services such that it causes those services to exceed the cap.

ICD-9 Codes That Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity

When using this table, refer to the ICD-9-CM code book for coding instructions. Some contractors' Local Coverage Determinations do not allow the use of some of the codes on this list in the primary diagnosis position on a claim. If the contractor has determined that these codes do not characterize patients who require medically necessary services, providers/suppliers may not use these codes, but must utilize a *contractor listed* billable diagnosis code to describe the patient's condition. Providers/suppliers may use the automatic process for exception for medically necessary services when the patient has a *contractor listed* billable condition that is not on the list below. In that case, the diagnosis on the list below must be put in a secondary position on the claim and/or in the medical records, as the contractor directs. When two codes are listed in the left cell in a row, all the codes between them are also accepted. If one code is in the cell, only that one code is accepted. The descriptions in the table are not always identical to those in the ICD-9 code book, but may be summaries. Contact your contractor for interpretation if you are not sure that a condition or complexity is applicable for automatic process exception.

Key	
Automatic (only ICD-9 needed on claim)	X
Complexity (requires another ICD-9 on claim)	*
Does not serve as qualifying ICD-9 on claim	--

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
V43.61-V43.69	Joint Replacement	X	X	--
V45.4	Arthrodesis Status	*	*	--
V45.81-V45.82 and V45.89	Other Postprocedural Status	*	*	--
V49.61-V49.67	Upper Limb Amputation Status	X	X	--
V49.71-V49.77	Lower Limb Amputation Status	X	X	--
V54.10-V54.29	Aftercare for Healing Traumatic or Pathologic Fracture	X	X	--
V58.71-V58.78	Aftercare Following Surgery to Specified Body Systems, Not Elsewhere Classified	*	*	*
244.0-244.9	Acquired Hypothyroidism	*	*	*
250.00-251.9	Diabetes Mellitus and Other Disorders of Pancreatic Internal Secretion	*	*	*
276.0-276.9	Disorders of Fluid, Electrolyte, and Acid-Base Balance	*	*	*
278.00-278.01	Obesity and Morbid Obesity	*	*	*
280.0-289.9	Diseases of the Blood and Blood-Forming Organs	*	*	*
290.0-290.43	Dementias	*	*	*
294.0-294.9	Persistent Mental Disorders due to Conditions Classified Elsewhere	*	*	*
295.00-299.91	Other Psychoses	*	*	*
300.00-300.9	Anxiety, Disassociative and Somatoform Disorders	*	*	*
310.0-310.9	Specific Nonpsychotic Mental Disorders Due to Brain Damage	*	*	*

Physical, Occupational & Speech Therapy Billing Guide

311	<i>Depressive Disorder, Not Elsewhere Classified</i>	*	*	*
315.00-315.9	<i>Specific delays in Development</i>	*	*	*
317	<i>Mild Mental Retardation</i>	*	*	*
320.0-326	<i>Inflammatory Diseases of the Central Nervous System</i>	*	*	*
330.0-337.9	<i>Hereditary and Degenerative Diseases of the Central Nervous System</i>	X	X	X
340-345.91 and 348.0-349.9	<i>Other Disorders of the Central Nervous System</i>	X	X	X
353.0-359.9	<i>Disorders of the Peripheral Nervous system</i>	X	X	--
365.00-365.9	<i>Glaucoma</i>	*	*	*
369.00-369.9	<i>Blindness and Low Vision</i>	*	*	*
386.00-386.9	<i>Vertiginous Syndromes and Other Disorders of Vestibular System</i>	*	*	*
389.00-389.9	<i>Hearing Loss</i>	*	*	*
401.0-405.99	<i>Hypertensive Disease</i>	*	*	*
410.00-414.9	<i>Ischemic Heart Disease</i>	*	*	*
415.0-417.9	<i>Diseases of Pulmonary Circulation</i>	*	*	*
420.0-429.9	<i>Other Forms of Heart Disease</i>	*	*	*
430-438.9	<i>Cerebrovascular Disease</i>	X	X	X
440.0-448.9	<i>Diseases of Arteries, Arterioles, and Capillaries</i>	*	*	*
451.0-453.9 and 456.0-459.9	<i>Diseases of Veins and Lymphatics, and Other Diseases of Circulatory System</i>	*	*	*
465.0-466.19	<i>Acute Respiratory Infections</i>	*	*	*
478.30-478.5	<i>Paralysis, Polyps, or Other Diseases of Vocal Cords</i>	*	*	*
480.0-486	<i>Pneumonia</i>	*	*	*
490-496	<i>Chronic Obstructive Pulmonary Disease and Allied Conditions</i>	*	*	*
507.0-507.8	<i>Pneumonitis due to solids and liquids</i>	*	*	*
510.0-519.9	<i>Other Diseases of Respiratory System</i>	*	*	*
560.0-560.9	<i>Intestinal Obstruction Without Mention of Hernia</i>	*	*	*
578.0-578.9	<i>Gastrointestinal Hemorrhage</i>	*	*	*
584.5-586	<i>Renal Failure and Chronic Kidney Disease</i>	*	*	*
590.00-599.9	<i>Other Diseases of Urinary System</i>	*	*	*
682.0-682.8	<i>Other Cellulitis and Abscess</i>	*	*	--
707.00-707.9	<i>Chronic Ulcer of Skin</i>	*	*	--
710.0-710.9	<i>Diffuse Diseases of Connective Tissue</i>	*	*	*
711.00-711.99	<i>Arthropathy Associated with Infections</i>	*	*	--
712.10-713.8	<i>Crystal Arthropathies and Arthropathy Associated with Other Disorders Classified Elsewhere</i>	*	*	--
714.0-714.9	<i>Rheumatoid Arthritis and Other Inflammatory Polyarthropathies</i>	*	*	--
715.00-715.98	<i>Osteoarthritis and Allied Disorders (Complexity except as listed below)</i>	*	*	--
715.09	<i>Osteoarthritis and allied disorders, multiple sites</i>	X	X	--
715.11	<i>Osteoarthritis, localized, primary, shoulder region</i>	X	X	--
715.15	<i>Osteoarthritis, localized, primary, pelvic region and thigh</i>	X	X	--
715.16	<i>Osteoarthritis, localized, primary, lower leg</i>	X	X	--
715.91	<i>Shoulder</i>	X	X	--
715.96	<i>Osteoarthritis, unspecified if gen. or local, lower leg</i>	X	X	--
716.00-716.99	<i>Other and Unspecified Arthropathies</i>	*	*	--
717.0-717.9	<i>Internal Derangement of Knee</i>	*	*	--
718.00-718.99	<i>Other Derangement of Joint (Complexity except as listed below)</i>	*	*	--
718.49	<i>Contracture of Joint, Multiple Sites</i>	X	X	--
719.00-719.99	<i>Other and Unspecified Disorders of Joint (Complexity except as listed below)</i>	*	*	--
719.7	<i>Difficulty Walking</i>	X	X	--

Physical, Occupational & Speech Therapy Billing Guide

720.0-724.9	<i>Dorsopathies</i>	*	*	--
725-729.9	<i>Rheumatism, Excluding Back (Complexity except as listed below)</i>	*	*	--
726.10-726.19	<i>Rotator Cuff Disorder and Allied Syndromes</i>	X	X	--
727.61-727.62	<i>Rupture of Tendon, Nontraumatic</i>	X	X	--
730.00-739.9	<i>Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities (Complexity except as listed below)</i>	*	*	--
733.00	<i>Osteoporosis</i>	X	X	--
741.00-742.9 and 745.0-748.9 and 754.0-756.9	<i>Congenital Anomalies</i>	*	*	*
780.31-780.39	<i>Convulsions</i>	*	*	*
780.71-780.79	<i>Malaise and Fatigue</i>	*	*	*
780.93	<i>Memory Loss</i>	*	*	*
781.0-781.99	<i>Symptoms Involving Nervous and Musculoskeletal System (Complexity except as listed below)</i>	*	*	*
781.2	<i>Abnormality of Gait</i>	X	X	--
781.3	<i>Lack of Coordination</i>	X	X	--
783.0-783.9	<i>Symptoms Concerning Nutrition, Metabolism, and Development</i>	*	*	*
784.3-784.69	<i>Aphasia, Voice and Other Speech Disturbance, Other Symbolic Dysfunction</i>	*	*	X
785.4	<i>Gangrene</i>	*	*	--
786.00-786.9	<i>Symptoms involving Respiratory System and Other Chest Symptoms</i>	*	*	*
787.2	<i>Dysphagia</i>	*	*	X
800.00-828.1	<i>Fractures (Complexity except as listed below)</i>	*	*	--
806.00-806.9	<i>Fracture of Vertebral Column With Spinal Cord Injury</i>	X	X	--
810.11-810.13	<i>Fracture of Clavicle</i>	X	X	--
811.00-811.19	<i>Fracture of Scapula</i>	X	X	--
812.00-812.59	<i>Fracture of Humerus</i>	X	X	--
813.00-813.93	<i>Fracture of Radius and Ulna</i>	X	X	--
820.00-820.9	<i>Fracture of Neck of Femur</i>	X	X	--
821.00-821.39	<i>Fracture of Other and Unspecified Parts of Femur</i>	X	X	--
828.0-828.1	<i>Multiple Fractures Involving Both Lower Limbs, Lower with Upper Limb, and Lower Limb(s) with Rib(s) and Sternum</i>	X	X	--
830.0-839.9	<i>Dislocations</i>	X	X	--
840.0-848.8	<i>Sprains and Strains of Joints and Adjacent Muscles</i>	*	*	--
851.00-854.19	<i>Intracranial Injury, excluding those With Skull Fracture</i>	X	X	X
880.00-884.2	<i>Open Wound of Upper Limb</i>	*	*	--
885.0-887.7	<i>Traumatic Amputation, Thumb(s), Finger(s), Arm and Hand (complete)(partial)</i>	X	X	--
890.0-894.2	<i>Open Wound Lower Limb</i>	*	*	--
895.0-897.7	<i>Traumatic Amputation, Toe(s), Foot/Feet, Leg(s) (complete)(partial)</i>	X	X	--
905.0-905.9	<i>Late Effects of Musculoskeletal and Connective Tissue Injuries</i>	*	*	*
907.0-907.9	<i>Late Effects of Injuries to the Nervous System</i>	*	*	*
941.00-949.5	<i>Burns</i>	*	*	*
952.00-952.9	<i>Spinal Cord Injury Without Evidence of Spinal Bone Injury</i>	X	X	X
953.0-953.8	<i>Injury to Nerve Roots and Spinal Plexus</i>	X	X	*
959.01	<i>Head Injury, Unspecified</i>	X	X	X

Additional Considerations for Exceptions

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables that affect appropriate treatment shall also be

Physical, Occupational & Speech Therapy Billing Guide

considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical/common sense.

Physical, Occupational & Speech Therapy Billing Guide

However, in cases where the beneficiary was treated in the same year for different episodes of the same condition, special attention should be paid to justifying the second episode as appropriate and necessary and not merely an extension of the first episode, separated so as to fabricate a complexity to justify the exception to therapy caps. If the services are appropriate, they should meet other criteria for exception.

Note that the patient's lack of access to outpatient hospital therapy services alone does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship or lack of therapy services at hospitals in the beneficiary's county may or may not qualify for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not.

Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps. The DRA (Deficit Reduction Act) allows that certain services that would not be covered due to caps, but are medically necessary, may be covered if they meet certain criteria. Therefore, when a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial. *Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish and these services.*

Services without a Medicare benefit may be billed to Medicare with a GY modifier for the purpose of obtaining a denial that can be used with other insurers.

Appeals

If a beneficiary whose exception services do not meet the Medicare criteria for medical necessity elects to receive such services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process.

QUALIFICATIONS

Physical Therapist

The new regulation provides that a qualified physical therapist is a person who is licensed, if applicable, as a physical therapist by the State in which they are practicing unless licensure does not apply, has graduated from an accredited PT education program and passed a national examination approved by the state in which the PT services are provided.

The curriculum accreditation is provided by the Commission on Accreditation in Physical Therapy Education (CAPTE) or, for those who graduated before CAPTE, curriculum approval was provided by the American Physical Therapy Association (APTA).

For internationally educated PTs, curricula are approved by a credentials evaluation organization either approved by the APTA or identified in 8 CFR 212.15(e) as it relates to PTs. For example, in 2007, 8 CFR 212.15(e) approved the credentials evaluation provided by the Federation of State Boards of Physical Therapy (FSBPT) and the Foreign Credentialing Commission on Physical Therapy (FCCPT).

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

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

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

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

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

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

- admitted to membership by the APTA; or
- admitted to registration by the American Registry of Physical Therapists; or
- graduated from a 4-year PT curriculum approved by a State Department of Education; or

Physical, Occupational & Speech Therapy Billing Guide

- licensed or registered and prior to January 1, 1970, they had 15 years of full-time experience in PT under the order and direction of attending and referring doctors of medicine or osteopathy.

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

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

Physical Therapy Assistant (PTA)

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

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

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

1. Is licensed or otherwise regulated in the state in which practicing; or
2. In states that have no licensure or other regulations, or where licensure does not apply, PTAs have:
 - graduated on or before December 31, 2009, from a 2-year college-level program approved by the APTA or CAPTE; and
 - effective January 1, 2010, those PTAs must have both graduated from a CAPTE approved curriculum and passed a national examination for PTAs; or

Physical, Occupational & Speech Therapy Billing Guide

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

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

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.

NOTE: Physical Therapy Assistants (PTAs) are not eligible to enroll as a Medicare B provider.

Occupational Therapist

Reference: 42CFR484.4

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

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

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

- they are licensed or otherwise regulated as an OT in the state in which practicing (regardless of the qualifications they met to obtain that licensure or regulation); or

Physical, Occupational & Speech Therapy Billing Guide

- when licensure or other regulation does not apply, OTs have graduated from an OT education program accredited by ACOTE and are eligible to take, or have successfully completed the NBCOT examination for OTs.

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

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

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

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

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

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

Occupational Therapy Assistant (OTA)

Reference: 42CFR 484.4

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

Physical, Occupational & Speech Therapy Billing Guide

state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services.

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

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

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

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

- completed certification requirements to practice as an OTA established by a credentialing organization approved by AOTA; or
- completed the requirements to practice as an OTA applicable in the state in which practicing.

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

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.

NOTE: Occupational Therapy Assistants (OTAs) are not eligible to enroll as a Medicare B provider. An occupational therapist must supervise OTAs.

Speech-Language Pathology

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment

Physical, Occupational & Speech Therapy Billing Guide

for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

SLPs in private practice may begin the Medicare enrollment process on June 2, 2009. Once enrolled, CMS will accept claims for services submitted by SLPs in private practice for services furnished on or after July 1, 2009.

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.

Qualified Speech-Language Pathologist Defined

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

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

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

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.

Application of Medicare Guidelines to Speech-Language Pathology Services

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

Physical, Occupational & Speech Therapy Billing Guide

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.

Impairments of the Auditory System

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

For example:

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

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

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

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.

SERVICES PROVIDED INCIDENT TO

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 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 or occupational therapist 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 bylaw. The qualified personnel must meet all the other requirements except licensure. 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. *On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide therapy incident to the services of a physician/NPP.*

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 or occupational therapy. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, or any other profession may not be billed as therapy services.

THERAPY ASSISTANTS AS CLINICAL INSTRUCTORS

Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

THERAPY STUDENTS

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist. However, the presence of the student "in the room" does not make the service unbillable. Medicare Part B will pay for the direct (one-to-one) patient contact services of the

Physical, Occupational & Speech Therapy Billing Guide

physician or therapist provided to Medicare B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present “in the room”.

Examples

Therapists may bill and be reimbursed for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services.)

SUPPORT PERSONNEL AND SUPPLIES

Aides

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. The supporting personnel must be employees of the therapist.

Supplies

The cost of supplies (e.g., theraband, hand putty, electrodes, looms, ceramic tiles or leather) 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. The restriction on separate coverage and billing does not apply to items meeting the definition of a brace.

PRIVATE PRACTICE

Private practice can be defined as an unincorporated solo practice, unincorporated partnership, unincorporated group practice, physician/NPP group or groups that are not professional corporations, if allowed by State and law. Physician/NPP group practices may employ physical therapists in private practice (PTPPs) occupational therapists in private practice (OTPPs) and/or speech language pathologist (SLP) if this employee relationship is permitted by State law. The PTPP, OTPP and SLP can be either salaried W-2 employees or contract 1099 employees. Benefits must be reassigned to the group. However, therapy provided to Medicare beneficiaries must be done while under the "care of a physician who is a doctor of medicine, osteopathy, podiatric medicine or optometry (low vision rehabilitation only)" or a non-physician practitioner. These physicians or non-physician practitioners provide referrals, certification and recertification of plans of care for Medicare beneficiaries.

Physical, Occupational & Speech Therapy Billing Guide

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 would have to be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice.

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

THERAPY PROVIDED BY PHYSICIANS AND PHYSICIAN EMPLOYEES

The following applies to physical and occupational services provided by physicians, non-physician practitioners (NPP) or an incident-to employee in the office or home:

- The patient must be under care of the physician for a condition that is medically necessary, reasonable and appropriate for therapy treatment.
- The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
- The services must be of a level of complexity that requires that they be performed by or under the direct supervision of the physician. Services which do not require the performance or supervision of the physician are not considered reasonable or necessary therapy services even if they are performed or supervised by a physician.
- Services must be furnished under a plan of treatment that has been written and developed by the physician caring for the patient. The plan must be established prior to the initiation of treatment, must be signed by the physician, and must be incorporated into the physician's permanent record for the patient. The services provided must relate directly to the written treatment regimen.
 1. The plan of care contains the following information:
 - The patient's significant past history;
 - Patient's diagnoses that require physical therapy;
 - Related physician orders;
 - Therapy goals and potential for achievement;
 - Any contraindications;
 - Patient's awareness and understanding of diagnoses, prognosis, treatment goals; and
 - When appropriate, the summary of treatment provided and results achieved

Physical, Occupational & Speech Therapy Billing Guide

during previous periods of physical therapy services.

Physical, Occupational & Speech Therapy Billing Guide

2. The plan of care indicates anticipated goals and specifies for the therapy services type, amount, frequency and duration. The amount, frequency and duration of the physical therapy services must be reasonable and necessary.
 3. The plan of care and results of treatment are reviewed every 30 days. When services are continued for more than 30 days, the physician must recertify the plan of treatment every 30 days. Any change in treatment plan must be noted in writing in the patient record. *(Note: The timing of recertification changed on January 1, 2008. Certifications on or after January 1, 2008 should be signed at least 90 days after the initiation of treatment under that plan. Certifications signed on or prior to December 31, 2007, follow the rules above which require recertification every 30 calendar days.)*
- The therapy services provided to the beneficiary must be restorative or for the purpose of designing and teaching a maintenance program for the patient to conduct at home. 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. If the patient's expected restoration potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, the therapy would not be considered reasonable and necessary. If at any point in the treatment it is determined that improvement in the patient's condition will not be achieved, the services will no longer be considered reasonable and necessary.

NOTE: Services that are palliative in nature are not considered necessary and reasonable and are not covered services. These services maintain function and generally do not involve complex therapy procedures nor do they require physician judgment and skill for safety and effectiveness.

CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY

Outpatient physical therapy and occupational therapy services furnished to a beneficiary are payable only when furnished in accordance with the following conditions:

- Such services are or were required because the individual needed therapy services;
- 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;
- Such services are or were furnished while the individual is or was under the care of a physician, and
- Services must be furnished on an outpatient basis. 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.

PLAN OF CARE FOR OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY

Establishing the Plan

The services must relate directly and specifically to a written treatment plan. 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.

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

- A physician/NPP (consultation with the treating physical therapist or occupational therapist is recommended. Only a physician may establish a plan of care in a Comprehensive Outpatient Rehabilitation Facility/CORF);
- The physical therapist who will provide the physical therapy services or
- The occupational therapist who will provide the occupational therapy services.
- 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.

Two Plans

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

clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.

Contents of Plan

The plan of care shall contain, at minimum, the following information as required:

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

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

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

The type of treatment may be physical therapy, occupational therapy or speech-language pathology, or, where appropriate, the type may be a description of a specific treatment or intervention. For example, when there is a single evaluation service, but the type is not specified, the type is assumed to be consistent with the therapy discipline (physical therapy, occupational therapy, speech-language pathology) ordered, or of the therapist who provided the evaluation. When a physician/NPP establishes a plan, the plan must specify the type (physical therapy, occupational therapy, speech-language pathology) of therapy planned.

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

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

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

The duration is the number of weeks, or the number of treatment sessions, for **this plan** of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of

Physical, Occupational & Speech Therapy Billing Guide

a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

Physical, Occupational & Speech Therapy Billing Guide

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

It may be appropriate for therapists to taper the frequency of visits as the patient progresses toward an independent or caregiver assisted self management program with the intent of improving outcomes and limiting treatment time. For example, treatment may be provided 3 times a week for 2 weeks, then 2 times a week for the next 2 weeks, then once a week for the last 2 weeks. Depending on the individual's condition, such treatment may result in better outcomes, or may result in earlier discharge than routine treatment 3 times a week for 4 weeks.

When tapered frequency is planned, the exact number of treatments per frequency level is not required to be projected in the plan, because the changes should be made based on assessment of daily progress. Instead, the beginning and end frequencies shall be planned. For example, amount, frequency and duration may be documented as "once daily, 3 times a week tapered to once a week over 6 weeks". Changes to the frequency may be made based on the clinicians clinical judgment and do not require recertification of the plan unless requested by the physician/NPP. The clinician should consider any comorbidities, tissue healing, the ability of the patient **and/or caregiver to do more independent self management** as treatment progresses, and any other factors related to frequency and duration of treatment.

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

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) or
- The speech-language pathologist (in the case of speech-language pathology services);
- The qualified occupational therapist (in the case of occupational therapy) 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. A change in long-term goals would be a significant change. Physician/NPP certification of the significantly modified plan of care shall be obtained within 30 days of the initial therapy treatment under the revised plan.

Physical, Occupational & Speech Therapy Billing Guide

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 or adjustments to the plan due to lack of expected response to the planned intervention, when the goals remain unchanged.. Only when the patient's condition changes significantly, making revision of long term goals necessary, is a physician's/NPP's signature required on the change, (long term goal changes may be accompanied by changes to procedures and modalities).

CERTIFICATION AND RECERTIFICATION OF NEED FOR TREATMENT AND THERAPY PLANS OF CARE

NOTE: The following rules apply to claims for physical and occupational therapy on or after January 1, 2008. Implementation: 6-9-08 Reference 42CFR424.24©

See specific certification rules in Pub. 100-01, chapter 4, §20 for hospital services

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 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. For example, if during the course of treatment under a certified plan of care a physician sends an order for continued treatment for 2 more weeks, contractors shall accept the order as certification of continued treatment for 2 weeks under the same plan of care. If the new certification is for less treatment than previously planned and certified, this new certification takes the place of any previous certification. At the end of the 2 weeks of treatment (which might extend more than 2 calendar weeks from the date the order/certification was signed) another certification would be required if further treatment was documented as medically necessary.

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

Initial Certification

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 for the duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.

Timing of Initial Certification

The provider should obtain certification as soon as possible after the plan of care is established, unless the requirements of delayed certification are met. "As soon as possible" means that the physician/NPP shall certify the *initial* plan as soon as it is obtained, or *within* 30 days of the initial therapy treatment.

Since payment may be denied if a physician does not certify the plan, the therapist should forward the plan to the physician as soon as it is established. Evidence of diligence in providing the plan to the physician may be considered by the *Medicare* contractor during review in the event of a delayed certification.

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

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

Review of Plan and Recertification

Reference: 42CFR424.24(c), 1861(r), [42CFR 410.61\(e\)](#).

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

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

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

Physician /NPP Options for Certification

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

Physicians/NPPs may require that the patient make a physician/NPP visit for an examination if, in the professional's judgment, the visit is needed prior to certifying the plan, or during the planned treatment.

Physicians/NPPs should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care that is certified.

If the physician wishes to restrict the patient's treatment beyond a certain date when a visit is required, the physician should certify a plan only until the date of the visit. After that date, services will not be considered reasonable and necessary due to lack of a certified plan. Physicians/NPPs should not sign a certification if they require a visit and a visit was not made. However, Medicare does not require a visit unless a National Coverage Determination (NCD) for a particular treatment requires it.

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.

Delayed Certification

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

Physical, Occupational & Speech Therapy Billing Guide

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

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

Example:

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

Example:

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

Example:

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

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).

Physical, Occupational & Speech Therapy Billing Guide

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.

Documentation Requirements for Therapy Services

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

General

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

The documentation guidelines identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. State or local laws and policies, or the policies of the profession, the practice, or the facility may be more stringent. Additional documentation not required by Medicare is encouraged when it conforms to state or local law or to professional guidelines of the American

Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language Hearing Association. It is encouraged but not required that narratives that specifically justify the medical necessity of services be included in order to support approval when those services are reviewed.

Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or

Physical, Occupational & Speech Therapy Billing Guide

qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

Documentation Required

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

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

Limits on Requirements

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

Dictated Documentation

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

Dates for Documentation

The date the documentation was made is important only to establish the date of the initial plan of care because therapy cannot begin until the plan is established unless treatment is performed or supervised by the same clinician who establishes the plan. However, contractors may require that treatment notes and progress reports be entered into the record within 1 week of the last date to which the Progress Report or Treatment Note refers.

Physical, Occupational & Speech Therapy Billing Guide

Example:

If treatment began on the first of the month at a frequency of twice a week, a Progress Report would be required at the end of the month. Contractors may require that the Progress Report that describes that month of treatment be dated not more than 1 week after the end of the month described in the report.

Document Information to Meet Requirements

In documenting records, clinicians must be familiar with the requirements for covered and payable outpatient therapy services as described in the manuals.

For example, the records should justify:

- The patient is under the care of a physician/NPP;
 - Physician/NPP care shall be documented by physician/NPP certification (approval) of the plan of care; and
 - Although not required, other evidence of physician/NPP involvement in the patient's care may include, for example: order/referral, conference, team meeting notes, and correspondence.
- Services require the skills of a therapist.

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

- A therapist's skill may also be required for safety reasons, if an unstable fracture requires the skill of a therapist to do an activity that might otherwise be done independently by the patient at home. Or the skill of a therapist might be required for a patient learning compensatory swallowing techniques to perform cervical auscultation and identify changes in voice and breathing that might signal aspiration. After the patient is judged safe for independent use of these compensatory techniques, the skill of a therapist is not required to feed the patient, or check what was consumed.
- Services are of appropriate type, frequency, intensity and duration for the individual needs of the patient.
- Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.

- Clinicians and contractors shall determine typical services using published professional literature and professional guidelines. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Services that exceed those typically billed should be carefully documented to justify their necessity, but are payable if the individual patient benefits from medically necessary services. Also, some services or episodes of treatment should be less than those typically billed, when the individual patient reaches goals sooner than is typical.
- Documentation should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can happen during treatment. It is recommended that the reasons for lack of progress be noted and the justification for continued treatment be documented if treatment continues after regression or plateaus.

Needs of the Patient

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

Evaluation/Re-Evaluation and Plan of Care

The initial evaluation, or the plan of care including an evaluation, should document the necessity for a course of therapy through objective findings and subjective patient self-reporting. Utilize the guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language and Hearing Association as guidelines, and not as policy. Only a clinician may perform an initial examination, evaluation, re-evaluation and assessment or establish a diagnosis or a plan of care. A clinician may include, as part of the evaluation or re-evaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others. Documentation of the evaluation should list the conditions and complexities and, where it is not obvious, describe the impact of the conditions and complexities on the prognosis and/or the plan for treatment such that it is clear to the contractor who may review the record that the services planned are appropriate for the individual.

Evaluation shall include:

A diagnosis (where allowed by state and local law) and description of the specific problem(s) to be evaluated and/or treated. The diagnosis should be specific and as relevant to the problem to be treated as possible. In many cases, both a medical diagnosis (obtained from a physician/NPP) and an impairment based treatment diagnosis related to treatment are relevant. The treatment

diagnosis may or may not be identified by the therapist, depending on their scope of practice. Where a diagnosis is not allowed, use a condition description similar to the appropriate ICD-9 code. For example the medical diagnosis made by the physician is CVA; however, the treatment diagnosis or condition description for PT may be abnormality of gait, for OT, it may be hemiparesis, and for SLP, it may be dysphagia. For PT and OT, be sure to include the body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;

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

- National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association
- Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO)
- Activity Measure – Post Acute Care (AM-PAC)
- OPTIMAL by Cedaron through the American Physical Therapy Association

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

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

- Identification of other health services concurrently being provided for this condition (e.g., physician, PT, OT, SLP, chiropractic, nurse, respiratory therapy, social services, psychology, nutritional/dietetic services, radiation therapy, chemotherapy etc.)
- Identification of durable medical equipment needed for this condition.
- Identification of the number of medications the beneficiary is taking (and type if known).
- If complicating factors (complexities) affect treatment, describe why or how. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but in some patients such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception to caps for necessary services. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient's condition as reported on a functional measurement tool may be so great as to suggest extended treatment is anticipated.

Physical, Occupational & Speech Therapy Billing Guide

- Generalized or multiple conditions. The beneficiary has, in addition to the primary condition being treated, another disease or condition being treated, or generalized musculoskeletal conditions, or conditions affecting multiple sites and these conditions will directly and significantly impact the rate of recovery.
- Mental or cognitive disorder. The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery.
- Identification of factors that impact severity including e.g., age, time since onset, cause of the condition, stability of symptoms, how typical/atypical are the symptoms of the diagnosed condition, availability of an intervention/treatment known to be effective, predictability of progress.

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

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

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

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

Documentation required to indicate beneficiary social support including, specifically,

- Where does the beneficiary live (or intend to live) at the conclusion of this outpatient therapy episode? (e.g., private home, private apartment, rented room, group home, board and care apartment, assisted living, SNF), and
- Who does beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode? (e.g., lives alone, spouse/significant other, child/children, other relative, unrelated person(s), personal care attendant), and
- Does the beneficiary require this outpatient therapy plan of care in order to return to a pre-morbid (or reside in a new) living environment, and
- Does the beneficiary require this outpatient therapy plan of care in order to reduce Activities of Daily Living (ADL) or Instrumental Activities of Daily (IADL) assistance to a

Physical, Occupational & Speech Therapy Billing Guide

premorbid level or to reside in a new level of living environment (document prior level of independence and current assistance needs); and

- * Documentation required to indicate objective, measurable beneficiary physical function including, e.g.,
- Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
 - Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
 - Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.
 - Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and

A determination that treatment is not needed, or, if treatment is needed a prognosis for return to pre-morbid condition or maximum expected condition with expected time frame and a plan of care.

When the Evaluation Serves as the Plan of Care

When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, and duration of treatment are implied in the diagnosis and one-time service.

The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. A referral/order dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient.

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

Re-evaluations

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

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

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

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

Plan of Care

The evaluation and plan may be reported in two separate documents or a single combined document.

Progress Report

The Progress Report provides justification for the medical necessity of treatment. Contractors shall determine the necessity of services based on the delivery of services as directed in the plan and as documented in the Treatment Notes and Progress Report. For Medicare payment purposes, information required in Progress Reports shall be written by a clinician that is, either the physician/NPP who provides or supervises the services, or by the therapist who provides the services and supervises an assistant. It is not required that the referring or supervising physician/NPP sign the Progress Reports written by a PT, OT or SLP.

Timing

The minimum Progress Report Period shall be at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation or treatment.

Regardless of the date on which the report is actually written (and dated), the end of the Progress Report Period is either a date chosen by the clinician, the 10th treatment day, or the 30th calendar day of the episode of treatment, whichever is shorter. The next treatment day begins the next reporting period. The Progress Report Period requirements are complete when both the elements of the Progress Report and the clinician's active participation in treatment have been documented.

Example:

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

Note: The dates for recertification of plans of care do not affect the dates for required Progress Reports. (Consideration of the case in preparation for a report may lead the therapist to request early recertification. However, each report does not require recertification of the plan, and there may be several reports between recertifications). In many settings, weekly Progress Reports are voluntarily prepared to review progress, describe the skilled treatment, update goals, and inform physician/NPPs or other staff. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary. Particularly where the patient's medical status, or appropriate tapering of frequency due to expected progress towards goals, results in limited frequency e.g., (2-4 times a month), more frequent Progress Reports can differentiate rehabilitative from maintenance treatment, document progress and justify the continued necessity for skilled care.

Absences

Holidays, sick days or other patient absences may fall within the Progress Report Period. Days on which a patient does not encounter qualified professional or qualified personnel for treatment, evaluation or re-evaluation do not count as treatment days. However, absences do not affect the requirement for a Progress Report at least once during each *Progress Report Period*. If the patient is absent unexpectedly at the end of the reporting period, when the clinician has not yet provided the required active participation during that reporting period, a Progress Report is still required, but without the clinician's active participation in treatment, the requirements of the Progress Report Period are incomplete.

Delayed Reports

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

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

Early Reports

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

Elements of Progress Reports may be written in the Treatment Notes if the provider/supplier or clinician prefers. If each element required in a Progress Report is included in the Treatment Notes

at least once during the Progress Report Period, then a separate Progress Report is not required. Also, elements of the Progress Report may be incorporated into a revised Plan of Care *when one is indicated*. Although the Progress Report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the *revised* Plan of Care accompanied by the Progress Report shall be re-certified by a physician/NPP.

Progress Reports for Services Billed Incident to a Physician's Service

The policy for incident to services requires, for example, the physician's initial service, direct supervision of therapy services, and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. Therefore, supervision and reporting requirements for supervising physician/NPPs supervising staff are the same as those for PTs and OTs supervising PTAs and OTAs with certain exceptions noted below.

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

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

Documenting Clinician Participation in Treatment in the Progress Report

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

Discharge Note

The Discharge Note (or Discharge Summary) is required for each episode of *outpatient* treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The Discharge Note shall be a Progress Report written by a clinician, and shall cover the reporting period from the last Progress Report to the date of discharge. In the case of a discharge unanticipated in the plan or previous Progress Report, the clinician may base any judgments required to write the report on the Treatment Notes and verbal reports of the assistant or qualified personnel.

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

At the discretion of the clinician, the discharge note may include additional information; for example, it may summarize the entire episode of treatment, or justify services that may have extended beyond those usually expected for the patient's condition. Clinicians should consider

the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed. The record should be reviewed and organized so that the required documentation is ready for presentation to the contractor if requested.

Assistant's Participation in the Progress Report

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

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

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the Progress Report may be used to add, change or delete short term goals. Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name, and date. Clinicians verify these changes by cosignatures on the report or in the clinician's Progress Report.

The evaluation and plan of care are considered incorporated into the Progress Report, and information in them is not required to be repeated in the report.

For example, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current Progress Report Period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3,) and the short term goals that relate to the long term goals may be numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. A clinician, an assistant on the order

of a therapist or qualified personnel on the order of a physician/NPP shall add new goals with new identifiers or letters. Omit reference to a goal after a clinician has reported it to be met, and that clinician's signature verifies the change.

Content of Clinician (Therapist, Physician/NPP) Progress Reports

In addition to the requirements above for notes written by assistants, the Progress Report of a clinician shall also include:

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

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

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

- The patient's condition has the potential to improve or is improving in response to therapy;
- Maximum improvement is yet to be attained; and
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

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

Example:

The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink thick liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks. Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia.

Short Term Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials.

Short Term Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%.

The Progress Report for 1/3/06 to 1/29/06 states: 1. Improved to 80% of trials; 2. Achieved. Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions.

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

Treatment Note

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

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

Documentation of each Treatment shall include the following required elements:

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

- Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment (i.e., the signature of Kathleen Smith, PTA, with notation of *phone consultation with Judy Jones, PT, supervisor*, when permitted by state and local law). The signature and identification of the supervisor need not be on each Treatment Note, unless the supervisor actively participated in the treatment. *Since a clinician must be identified on the Plan of Care and the Progress Report, the name and professional identification of the supervisor responsible for the treatment is assumed to be the clinician who wrote the plan or report.* When the treatment is supervised without active participation by the supervisor, the supervisor is not required to cosign the Treatment Note written by a qualified professional. When *the responsible* supervisor is absent, the presence of a similarly qualified supervisor on *the clinic roster* for that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation.

If a treatment is added or changed under the direction of a clinician during the treatment days between the Progress Reports, the change must be recorded and justified on the medical record, either in the Treatment Note or the Progress Report, as determined by the policies of the provider/supplier. New exercises added or changes made to the exercise program help justify that the services are skilled. For example: The original plan was for therapeutic activities, gait training and neuromuscular re-education. “On Feb. 1 clinician added electrical stim. to address shoulder pain.”

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

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

Refer to the “Reporting Units of Service” section in this manual on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes.

REQUIREMENT THAT SERVICES BE FURNISHED ON AN OUTPATIENT BASIS

Therapy services are payable under the Physician Fee Schedule when furnished by a provider to its outpatients in the patient's home; a provider to patients who come to the facility's outpatient department; a provider to inpatients of other institutions, or a supplier to patients in the office or in the patient's 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 no certified 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.

REASONABLE AND NECESSARY OUTPATIENT REHABILITATION THERAPY SERVICES

General

To be covered, services must be skilled therapy services 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.

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.
- 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 no skilled personnel.
- 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.

- 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.

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 no skilled 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 no skilled 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.

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.

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 unless the patient's safety was at risk.

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.

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.

PRACTICE OF OCCUPATIONAL THERAPY

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.

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 limitations.

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.

ADDITIONAL SERVICES

Hot Pack, Hydrocollator, Infra-Red Treatment, Paraffin Baths and Whirlpool Baths

Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified therapist, however in a particular case, the skills, knowledge, and judgment of a qualified therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given prior to but as an integral part of a skilled therapy procedure, they would be considered part of the therapy service. Services which do not require the performance or supervision of the physician are not considered reasonable or necessary therapy services even if they are performed or supervised by a physician.

Hot/Cold Packs

Payment for code **97010**, hot/cold packs, **is bundled** into payment for other related services. Separate payment is not allowed and providers can not bill Medicare beneficiaries separately for this service.

Gait Training 97116

Gait evaluation and training rendered to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a qualified therapist. However, if gait evaluation and training cannot reasonably be expected to improve significantly the patient's ability to walk, such services would not be considered reasonable and necessary.

Repetitive exercises to improve gait or maintain strength and endurance, and assistive walking, such as provided in support for feeble or unstable patients, are appropriately provided by supportive personnel e.g., aides or nursing personnel and do not require the skills of a qualified therapist.

Ultrasound, Shortwave, and Microwave Diathermy Treatment

These modalities must always be performed by or under the supervision of a qualified therapist, and therefore, such treatments constitute therapy.

Assessment

The skills of a physical therapist to assess and periodically reassess a patient's rehabilitation needs and potential or to develop and/or implement a physical therapy program are covered when they are reasonable and necessary because of the patient's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination,

endurance or functional ability.

Range of Motion Tests

Only the qualified therapist may perform range of motion tests and, therefore, such tests would constitute therapy. Range of motion exercises require the skills of a qualified therapist only when they are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidenced by therapy notes showing the degree of motion lost and the degree to be restored) and such exercises, either because of their nature or condition of the patient, may only be performed safely and effectively by or under the supervision of a qualified therapist. Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function do not require the skills of a qualified therapist.

Therapeutic Exercises 97110

Therapeutic exercises which must be performed by or under the supervision of a qualified therapist due either to the type of exercise employed or to the condition of the patient would constitute therapy.

Canalith Repositioning 97112

In the 2009 Medicare Physician Fee Schedule final rule, CMS created CPT code 95992 describing canalith repositioning procedures. This procedure is bundled into an Evaluation and Management services and therefore not paid separately. However, since therapists also provide this service and they cannot bill for E&M services, they should continue to bill 97112 for this service.

Group Therapy Services 97150

Carriers pay for outpatient physical therapy services and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services.

The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

Biofeedback Therapy

Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate

an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Biofeedback therapy differs from electromyography which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. An electromyography device may be used to provide feedback with certain types of biofeedback. Biofeedback therapy is covered

under Medicare only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, and support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions.

Biofeedback Therapy for the Treatment of Urinary Incontinence

Biofeedback is covered for the treatment of stress and/or urge incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. Biofeedback is not a treatment, per se, but a tool to help patients learn how to perform PME. Biofeedback-assisted PME incorporates the use of an electronic or mechanical device to relay visual and/or auditory evidence of pelvic floor muscle tone, in order to improve awareness of pelvic floor musculature and to assist patients in the performance of PME.

A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of pelvic muscle exercises to increase periurethral muscle strength.

Contractors may decide whether or not to cover biofeedback as an initial treatment modality.

NOTE: Home use of biofeedback therapy is not covered.

Wound Care Provided Within Scope of State Practice Acts

If wound care falls within the auspice of the physical therapist's State Practice Act then the physical therapist may provide the specific type of wound care services defined in the State Practice Act. Such visits in this specific situation can be billed as a physical therapy visit and count toward the therapy threshold item in the case-mix methodology.

Vertebral Axial Decompression (VAX-D)

The Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 2, Section 160.16 states that vertebral axial decompression is performed for symptomatic relief of pain associated with lumbar disk problems. The treatment combines pelvis and/or cervical traction connected to a special table that permits the traction application. There is insufficient scientific data to support the benefits of this technique. Therefore, VAX-D is not covered by Medicare. There are various types of VAX-D devices including but not limited to: VAX-D, DRX-3000, DRX9000, Decompression Reduction Stabilization (DRS) System, IDD, MedX, Spina System, Accu-Spina System, SpineMED Decompression Table, Lordex Traction Unit, Triton DTS, and the Z-Grav. Regardless of the manufacturer of the device, VAX-D is not a covered service under the Medicare program

BILLING AND CODING GUIDELINES

Place of Service

Coverage of services rendered by a qualified therapist in private practice is limited to those services rendered in the therapist's office or the beneficiary's home. Physical therapy services rendered by a therapist in the therapist's office *under arrangements* with a Hospital, Critical Access Hospital, Skilled Nursing Facility, Home Health Agency, Hospice, Comprehensive

Outpatient Rehabilitation Facility, Community Mental Health Center, clinic, rehabilitation agency, or public health agency or therapy services provided in the beneficiary's home *under arrangements* with a provider of outpatient therapy services is not covered under this provision. Such services are covered under Medicare Part A through the hospital, public health agency or outpatient therapy facility.

Places of Service (POS) include:

- 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.

Evaluation/Reevaluation

Procedure Code 97001 – Physical Therapy Evaluation

Evaluations are required prior to beginning therapy to determine the medical necessity of initiating rehabilitative or maintenance services. Patients must exhibit a significant change from normal functional ability to warrant an evaluation. The written evaluation must demonstrate the patient's need for skilled physical therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The therapist must have an expectation that the patient will achieve the established goals. Initial evaluations from other therapy disciplines performed on the beneficiary may also be covered, provided the referral, evaluation and plan of care are not duplicative.

Procedure code 97003 - Occupational Therapy Evaluation

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.

Procedure code 97002 – Physical Therapy Reevaluation

Therapy re-evaluations are separately payable if the documentation shows significant and unexpected change in the patient's condition that supports the need to perform a formal re-evaluation of the patient's status. When a patient exhibits a demonstrable change in physical functional ability, a re-evaluation is covered to re-establish appropriate treatment goals and interventions. Reassessments are considered a routine aspect of intervention and are not billed

separately from the charge for the intervention. Re-evaluations are not routinely covered for purposes of updating the plan of care.

The documentation should focus on assessing significant changes from the initial evaluation or progress toward treatment goals.

Procedure code 97004 - Occupational Therapy Reevaluation

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.

Modifiers

Modifiers are used to modify payment of a procedure code, assist in determining appropriate coverage or otherwise identify the detail on the claim. The use of modifiers becomes more important every day when reporting services to ensure appropriate reimbursement from Medicare. These codes should be entered in item 24d of the CMS-1500 claim form or the electronic equivalent.

Therapy Modifiers

Modifiers are used to identify therapy services whether financial limitations are in effect. When limitations are in effect, the financial limitation is based on the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes, except as noted. The modifiers do not allow a provider to deliver services they are not qualified and recognized by Medicare to perform. Therapy modifiers should never be used with codes that are not on the list of applicable therapy codes. This includes the codes for Physician Quality Reporting Initiative (PQRI)

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered.

Outpatient Therapy

GN - Services delivered under an outpatient SLP plan of care

GO – Services delivered under an outpatient OT plan of care

GP – Services delivered under an outpatient PT plan of care

KX - When the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a Local Coverage Determination by the contractor, are not medically necessary services. The KX modifier in addition to therapy modifier GO or GP is added to each line of the claim that contains a service that exceeds the cap.

This modifier represents the provider/supplier's attestation of medical necessity. Medical records continue to be subject to medical review for possible misrepresentation, fraud or pattern of abuse. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.***

Modifier 25- Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for

Physical, Occupational & Speech Therapy Billing Guide

reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier 25 to the appropriate level of E/M service.

Modifier 59 - Distinct Procedural Service

The provider may need to indicate that a service was distinct or separate from other services performed on the same day. This may be:

- A different session or patient encounter
- A different site
- A separate injury

Cautions

- Do not confuse modifier 59 with modifier 25.
- Modifier 59 relates to the Correct Coding Initiative (CCI) and should not be used for code combinations that are not subject to CCI.
- This modifier should only be used when no other modifier is appropriate.

The medical record must reflect that the modifier is being used appropriately to describe separate services. The documentation should be maintained in the patient's medial record and must be made available upon request.

Modifier 76 - Repeat Procedure by Same Provider

The provider may need to indicate that a service was repeated subsequent to the original service on the same day. In regard to therapy services, if the same procedure for a different diagnosis is rendered on the same day, modifier 76 will be indicated on the subsequent service.

- An explanation of the medical necessity for the repeat service is necessary. It may be entered in Item 19 of the CMS-1500 claim form or the comment field of the electronic version

Reporting of Service Units

Units are reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe, the provider enters "1" in units. If the treatment/procedure is defined as 15 minutes and the therapist provided 30 minutes of the treatment/procedure, then the therapist enters 2 in the units.

Example:

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on any calendar day using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

Units Reported on the Claim	Number Minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than 8 minutes. The expectation (based on the work values for these codes) is that a provider’s direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

The beginning and ending time of the treatment should be recorded in the patient’s medical record along with the note describing the treatment. The time spent delivering each service, described by a timed code, and should be recorded. (The length of the treatment to the minute could be recorded instead.) If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of code 97112 and 23 minutes of code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more units to the service that took the most time.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

Determining What Time Counts Towards 15-Minute Timed Codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as “intra-service care” begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

PROSPECTIVE PAYMENT SYSTEM (PPS)

Home Health Claims

Effective for home health claims with service dates on or after October 1, 2000, the Balanced Budget Act of 1997 requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician.

The law states payment will be made to the primary home health agency (HHA) whether or not the services was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements existed with the primary agency, or “otherwise.”

Therapy services, provided to beneficiaries under a home health plan of care, are included in consolidated billing. The therapy provider must look to the HHA, rather than the beneficiary or Medicare carrier, for payment. Further information on HHA claims and coding can be found by accessing: <http://www.cms.hhs.gov/HomeHealthPPS/>

Skilled Nursing Facility Consolidated Billing

Effective July 1, 1998, therapy services furnished to residents in a covered Part A or Part B stay of a skilled nursing facility (SNF) became part of consolidated billing. The therapy provider must look to the SNF, rather than the beneficiary or Medicare carrier, for payment. For a list of codes that are included in a Skilled Nursing Facility claim you may access:

http://www.cms.hhs.gov/snfconsolidatedbilling/01_overview.asp.

NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://cms.hhs.gov/BNI/>

ABN Modifiers

Modifier **GA** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as reasonable and necessary and they have on file an Advance Beneficiary Notification (ABN) signed by the beneficiary.

Modifier **GY** should be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

Modifier **GZ** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an Advance Beneficiary Notice (ABN) signed by the beneficiary.

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.hhs.gov/mcd/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

New England:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversified Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date**. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m.- Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m.- Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.hhs.gov/center/coverage.asp>

<http://www.cms.hhs.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.hhs.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.hhs.gov/CMSForms/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)	http://cms.hhs.gov/BNI/
American Medical Association	http://www.ama-assn.org/
CMS	http://www.cms.hhs.gov http://www.medicare.gov
CMS Correct Coding Initiative	http://www.cms.hhs.gov/NationalCorrectCodInitEd/
CMS Physician's Information Resource for Medicare	http://www.cms.hhs.gov/center/physician.asp?
Electronic Prescribing	http://www.cms.hhs.gov/erxincentive/

Evaluation and Management Documentation Guidelines

http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.hhs.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.hhs.gov/NationalProvIdentStand/>

NPI Registry

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.hhs.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	B. Bedard	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.hhs.gov>

<http://www.medicare.gov>