CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12425	**Date: December 21, 2023**
	Change Request 13496

SUBJECT: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92 - Additional Publication Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the new condition code 92 for Intensive Outpatient Program (IOP) services and enforce billing requirements.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/Table of Contents
R	6/20/Outpatient Hospital Services
R	6/70.1/General
R	6/70.3/Partial Hospitalization Services
N	6/70.4/Intensive Outpatient Services
R	7/40.1.2.15/Psychiatric Evaluation, Therapy, and Teaching
R	15/60/Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service
R	15/220/Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to

be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 12425	Date: December 21, 2023	Change Request: 13496

SUBJECT: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92 - Additional Publication Update

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to implement the change in the manual requirements of Chapters 6, 7, and 15, the Medicare Benefit Policy Manual 100-02, related to Coverage of Intensive Outpatient Program (IOP) Services, furnished on or After January 1, 2024, finalized in the CY 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Final Rule.

B. Policy: Section 4124 of the Consolidated Appropriations Act of 2023 establishes Medicare coverage and payment for IOP services for individuals with mental health needs when furnished by hospital outpatient departments, Critical Access Hospital (CAH) outpatient departments, and CMHCs. The law establishes this new benefit for services furnished on or after January 1, 2024.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13496 - 02.1	Medicare contractors shall refer to Pub.100-02, the Medicare Benefit Policy Manual, chapter 6, sections 20, 70.1, 70.3, and 70.4 for the latest revisions.	X		X						
13496 - 02.2	Medicare contractors shall refer to Pub.100-02, the Medicare Benefit Policy Manual, chapter 7, section 40.1.2.15 for the latest revisions.	X		X						
13496 - 02.3	Medicare contractors shall refer to Pub.100-02, the Medicare Benefit Policy Manual, chapter 15, sections 60 and 220 for the latest revisions.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13496 - 02.4	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Benefit Policy Manual

Chapter 6 - Hospital Services Covered Under Part B

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(Rev. 12425: Issued: 12-21-23)

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(Rev.12425; Issued: 12-21-23: Effective: 01-01-24; Implementation: 01-02-24)

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. Part B covers both the diagnostic and the therapeutic services furnished by hospitals to outpatients. The rules in this section pertaining to the coverage of outpatient hospital services are not applicable to the following services.

- Physical therapy, speech-language pathology or occupational therapy services when they are furnished "as therapy" meaning under a therapy plan of care. See chapter 15, sections 220 and 230 of this manual, for coverage and payment rules for these services, which are paid at the applicable amount under the physician fee schedule.

- Services that are covered and paid under the End Stage Renal Disease Prospective Payment System. See Chapter 11, "End Stage Renal Disease (ESRD)" of this manual, for rules on the coverage of these services.

For policies in addition to this section that apply to partial hospitalization services, see chapter 6, section 70.3 of this manual, and Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 260. *For policies in addition to this section that apply to intensive outpatient services, see chapter 6, section 70.4 of this manual, and Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 261.*

For rules on the coverage of services and supplies furnished incident to a physician's professional services in an office or physician-directed clinic setting, refer to Chapter 15, "Covered Medical and Other Health Services," section 60 of this manual.

70.1 - General

(Rev.12425; Issued: 12-21-23: Effective: 01-01-24; Implementation: 01-02-24)

There is a wide range of services and programs that a hospital may provide to its outpatients who need psychiatric care, ranging from a few individual services to comprehensive, full-day programs; from intensive treatment programs to those that provide primarily supportive *services*.

In general, to be covered the services must be:

- Incident to a physician's service (see §20.4); and

- Reasonable and necessary for the diagnosis or treatment of the patient's condition.

This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

A. Coverage Criteria

The services must meet the following criteria:

1. Individualized Treatment Plan

Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services are furnished.)

2. Physician Supervision and Evaluation

Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

3. Reasonable Expectation of Improvement

Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

Some patients may undergo a course of treatment that increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are noncovered only where the evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment.

B. Partial Hospitalization *and Intensive Outpatient Program*

Partial hospitalization is a distinct and organized intensive treatment program for patients who would otherwise require inpatient psychiatric care. See §70.3 for specific program requirements.

An intensive outpatient program is a distinct and organized ambulatory treatment program for patients who have an acute mental illness, including substance use disorder (SUD). Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization. See §70.4 for specific program requirements.

C. Application of Criteria

The following discussion illustrates the application of the above guidelines to the more common modalities and procedures used in the treatment of psychiatric patients and some factors that are considered in determining whether the coverage criteria are met.

1. Covered Services

Services generally covered for the treatment of psychiatric patients *(including patients with SUD)* are:

- Individual and group therapy with physicians, psychologists, or other mental health professionals *(including SUD professionals)* authorized by the State.

- Occupational therapy services are covered if they require the skills of a qualified occupational therapist and be performed by or under the supervision of a qualified occupational therapist or by an occupational therapy assistant.

- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients *(including patients with SUD)*. *These include principal illness navigation services provided by auxiliary staff, including peer support specialists.*

- Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be self-administered.

- Activity therapies but only those that are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

- Family counseling services. Counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of the patient's condition. *These include counseling services for caregivers.*

- Patient education programs, but only where the educational activities are closely related to the care and treatment of the patient. *These services include caregiver training services furnished for the benefit of the patient.*

- Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan.

2. Noncovered Services

The following are generally not covered except as indicated:

- Meals and transportation.

- Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

"Geriatric day care" programs are available in both medical and nonmedical settings. They provide social and recreational activities to older individuals who need some supervision during the day while other family members are away from home. Such programs are not covered since they are not considered reasonable and necessary for a diagnosed psychiatric disorder, nor do such programs routinely have physician involvement.

- Psychosocial programs. These are generally community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. Outpatient programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they are covered. However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it is not covered.

- Vocational training. While occupational therapy may include vocational and prevocational assessment and training, when the services are related solely to specific employment opportunities, work skills or work settings, they are not covered.

3. Frequency and Duration of Services

There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, evaluate the case in terms of the criteria to determine whether with continued treatment there is a reasonable expectation of improvement.

70.3 - Partial Hospitalization Services

(Rev.12425; Issued: 12-21-23: Effective: 01-01-24; Implementation: 01-02-24)

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

A. Program Criteria

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

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

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

B. Patient Eligibility Criteria

1. Benefit Category

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

Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP. Recertification must address the continuing serious nature of the patients' psychiatric condition requiring active treatment in a PHP.

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

2. Covered Services

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

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

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

- Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients *(including patients with SUD)*. *These include principal illness navigation services provided by auxiliary staff, including peer support specialists*;

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

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

- Family counseling services for which the primary purpose is the treatment of the patient's condition. *These include counseling services for caregivers*;

- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individuals care and treatment of his/her diagnosed psychiatric condition. *These services include caregiver training services furnished for the benefit of the patient*; and

- Medically necessary diagnostic services related to mental health treatment *(including SUD)*.

Partial hospitalization services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements in or of §1835(a)(2)(F) unless *the patient* also has the need for the active treatment provided by the program of services defined in §1861(ff). It is the need for *at least 20 hours per week of* intensive, active treatment of *the patient's* condition to maintain a functional level and to prevent relapse or hospitalization *that* qualifies the patient to receive the services identified in §1861(ff).

3. Reasonable and Necessary Services

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

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

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition *(including SUD)*, professional

services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

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

4. Reasons for Denial

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

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

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

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

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

- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a PHP; or
- Treatment of chronic conditions without acute exacerbation of symptoms that place the individual at risk of relapse or hospitalization.

5. Documentation Requirements and Physician Supervision

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

a. Initial Psychiatric Evaluation/Certification.--Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided *and that the patient requires at least 20 hours of services per week*. The certification should identify the diagnosis and *clinical* need for

the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms *(including SUD)* and to prevent relapse or hospitalization.

b. Physician Recertification Requirements.--

- Signature – The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.
- Timing – The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
- Content – The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:
- The patient's response to the therapeutic interventions provided by the PHP;
- The patient's psychiatric symptoms *(including SUD)* that continue to place the patient at risk of hospitalization; and
- Treatment goals for coordination of services to facilitate discharge from the PHP.

c. Treatment Plan.--Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms *(including SUD)* placing the patient at risk, do not qualify as partial hospitalization services.

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

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

70.4 - Intensive Outpatient Services

(Rev.12425; Issued: 12-21-23: Effective: 01-01-24; Implementation: 01-02-24)

Intensive outpatient programs (IOPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). An IOP furnishes treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a PHP. Programs providing primarily social, recreational, or diversionary activities are not considered intensive outpatient programs.

A. Program Criteria

IOPs work best as part of a community continuum of mental health services (including SUD services) which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served. IOPs may be covered under Medicare when they are provided by a hospital outpatient department, a Medicare-certified CMHC, a rural health clinic (RHC), a Federally qualified health center (FQHC), or an Opioid Treatment Program (OTP). See chapter 13 in this manual for RHCs and FQHCs; see chapter 17 in this manual for OTPs.

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

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

B. Patient Eligibility Criteria

1. Benefit Category

Patients must meet benefit requirements for receiving the intensive outpatient services as defined in §1861(ff) of the Act. Patients admitted to an IOP must be under the care of a physician who certifies the need for intensive outpatient services, including the need for a minimum of 9 hours per week of services, as evidenced by their plan of care. The patients also require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder (including SUD) which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature. In addition, IOP patients must be able to cognitively and emotionally participate in the active treatment process and be capable of tolerating the intensity of an IOP program.

Generally speaking, an IOP is less intensive than a PHP. For patients of an IOP, section 1835(a)(2)(F)(i) of the Act does not apply, that is, individuals receiving IOP do not require inpatient psychiatric care in the absence of such services. Patients meeting benefit category requirements for Medicare coverage of an IOP are those who need more intensive treatment than that provided by outpatient services, but who need less intensive treatment than that provided by a PHP. There must be evidence of the need for the acute, intense, structured combination of services provided by an IOP.

Recertification must address the continuing serious nature of the patients' psychiatric condition requiring active treatment in an IOP.

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

2. Covered Services

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

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

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

- *Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients (including patients with SUD). These include principal illness navigation services provided by auxiliary staff, including peer support specialists;*

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

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

- *Family counseling services for which the primary purpose is the treatment of the patient's condition. These include counseling services for caregivers;*

- *Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition. These services include caregiver training services furnished for the benefit of the patient; and*

- *Medically necessary diagnostic services related to mental health treatment (including SUD).*

Intensive outpatient services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is the need for at least 9 hours per week of intensive, active treatment of the patient's condition to maintain a functional level that qualifies the patient to receive the services identified in §1861(ff).

3. Reasonable and Necessary Services

This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition (including SUD) and, in combination, are reasonably expected to improve or maintain the individual's condition and functional level. A particular individual covered service (described above) as intervention, expected to maintain or improve the individual's condition and

prevent relapse or hospitalization, may also be included within the plan of care, but the overall intent of the intensive outpatient program is to treat the serious presenting psychiatric symptoms (including SUD). Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent relapse or hospitalization.

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

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

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

b. ***Reasons for Denial***

a. *Benefit category denials made under §1861(ff) are not appealable by the provider and the limitation on liability provision does not apply (HCFA Ruling 97-1). Examples of benefit category based in §1861(ff) of the Act for intensive outpatient program services generally include the following:*

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

b. *Coverage denials made under §1861(ff) of the Act are not appealable by the*

provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1). The following services are excluded from the scope of intensive outpatient services defined in §1861(ff) of the Social Security Act:

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

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

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

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

b. ***Documentation Requirements and Physician Supervision***

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

b. *Initial Psychiatric Evaluation/Certification.--Upon admission, certification by the physician must be made that the patient admitted to the IOP requires a minimum of 9 hours of services per week. The certification should identify the diagnosis and clinical need for the intensive outpatient program. Intensive outpatient services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in § 1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms (including SUD) and to prevent relapse or hospitalization.*

b. Physician Recertification Requirements.--

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

- *Timing – Recertifications are required at intervals established by the provider, but no less frequently than every 60 days following the initial IOP certification.*

- *Content – The recertification must specify that the patient requires a minimum of 9 hours of mental health treatment services per week and describe the following:*

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

- *The patient's psychiatric symptoms (including SUD) that continue to require intensive treatment; and*

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

c. *Treatment Plan.--An intensive outpatient program is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms (including SUD) placing the patient at risk, do not qualify as intensive outpatient program services.*

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

See the Medicare Claims Processing Manual, Chapter 4, "Hospital Outpatient Services," §261 for billing instructions for intensive outpatient program services.

40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching

(Rev.12425; Issued: 12-21-23: Effective: 01-01-24; Implementation: 01-02-24)

The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician or allowed practitioner.

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases. If a substantial number of an HHA's patients attend partial hospitalization *or intensive outpatient* programs or receive *other* outpatient mental health services, the Medicare contractor will verify whether the patients meet the eligibility requirements specified in §30 and whether the HHA is primarily engaged in care and treatment of mental disease.

Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for non-psychiatric diagnoses or to monitor the condition of a patient with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's normal living situation.

EXAMPLE 1:

A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a change in medication or hospitalization for over 2 years. During a visit by the nurse, the patient's spouse indicates that the patient is awake and pacing most of the night and has begun ruminating about perceived failures in life. The nurse observes that the patient does not exhibit an appropriate level of hygiene and is dressed inappropriately for the season. The nurse comments to the patient about her observations and tries to solicit information about the patient's general medical condition and mental status. The nurse advises the physician about the patient's general medical condition and the new symptoms and changes in the patient's behavior. The physician orders the nurse to check blood levels of medication used to treat the patient's medical and psychiatric conditions. The physician then orders the psychiatric nursing service to evaluate the patient's mental health and communicate with the physician about whether additional intervention to deal with the patient's symptoms and behaviors is warranted. The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.

EXAMPLE 2:

A patient is homebound after discharge following hip replacement surgery and is receiving skilled therapy services for range of motion exercise and gait training. In the past, the patient had been diagnosed with clinical depression and was successfully stabilized on medication. There has been no change in her symptoms. The fact that the patient is taking an antidepressant does not indicate a need for psychiatric nursing services.

EXAMPLE 3:

A patient was discharged after 2 weeks in a psychiatric hospital with a new diagnosis of major depression. The patient remains withdrawn; in bed most of the day, and refusing to leave home. The patient has a depressed affect and continues to have thoughts of suicide, but is not considered to be suicidal. Psychiatric

skilled nursing services are necessary for supportive interventions until antidepressant blood levels are reached and the suicidal thoughts are diminished further, to monitor suicide ideation, ensure medication compliance and patient safety, perform suicidal assessment, and teach crisis management and symptom management to family members. The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.

60 - Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service

(Rev.12425; Issued: 12-21-23: Effective: 01-01-24; Implementation: 01-02-24)

B3-2050

A - Noninstitutional Setting

For purposes of this section a noninstitutional setting means all settings other than a hospital or skilled nursing facility

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician's or other practitioner's services, are commonly included in the physician's or practitioner's bills, and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. A/B MACs (A) and (B) must not apply incident to requirements to services having their own benefit category. Rather, these services should meet the requirements of their own benefit category. For example, diagnostic tests are covered under §1861(s)(3) of the Act and are subject to their own coverage requirements. Depending on the particular tests, the supervision requirement for diagnostic tests or other services may be more or less stringent than supervision requirements for services and supplies furnished incident to physician's or other practitioner's services. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under §1861(s)(10) of the Act and need not also meet incident to requirements. (Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services. When their services are provided as auxiliary personnel (see under direct physician supervision, they may be covered as incident to services, in which case the incident to requirements would apply.

For purposes of this section, physician means physician or other practitioner (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, and clinical psychologist) authorized by the Act to receive payment for services incident to his or her own services.

To be covered incident to the services of a physician or other practitioner, services and supplies must be:

- An integral, although incidental, part of the physician's professional service (see §60.1);
- Commonly rendered without charge or included in the physician's bill (see §60.1A);
- Of a type that are commonly furnished in physician's offices or clinics (see §60.1A);
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision (see §60.1B).

B - Institutional Setting

Hospital services incident to physician's or other practitioner's services rendered to outpatients (including drugs and biologicals which are not usually self-administered by the patient), and partial hospitalization *and intensive outpatient* services incident to such services may also be covered.

The hospital's A/B MAC (A) makes payment for these services under Part B to a hospital.

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

(Rev.12425; Issued: 12-21-23: Effective: 01-01-24; Implementation: 01-02-24)

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

A. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the

progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

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

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

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

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

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

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

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

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

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701729, and 486.150-163.

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

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

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

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

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

B. References

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

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

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

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

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

- Pub.100-01 GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT

  o Chapter 1- General Overview

  10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and SNF Services - A Brief Description
  10.2 - Home Health Services
  10.3 - Supplementary Medical Insurance (Part B) - A Brief Description
  20.2 - Discrimination Prohibited

- Pub. 100-02, MEDICARE BENEFIT POLICY MANUAL

  o Ch 6 - Hospital Services Covered Under Part B

  10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals
  20 - Outpatient Hospital Services
  20.2 - Outpatient Defined
  20.4.1 - Diagnostic Services Defined
  70 - Outpatient Hospital Psychiatric Services

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

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

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

<u>10 - Comprehensive Outpatient Rehabilitation Facility (CORF) Services Provided by Medicare</u>
20 - Required and Optional CORF Services
  20.1 - Required Services
  20.2 - Optional CORF Services
30 - Rules for Provision of Services
  30.1 - Rules for Payment of CORF Services
40 - Specific CORF Services
  40.1 - Physicians' Services
  40.2 - Physical Therapy Services
  40.3 - Occupational Therapy Services
  40.4 – Speech Language Pathology Services

- Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL

  o Part 1

  20.10 - Cardiac Rehabilitation Programs

30.1 - Biofeedback Therapy
30.1.1 - Biofeedback Therapy for the Treatment of Urinary Incontinence
50.1 – Speech Generating Devices
50.2 - Electronic Speech Aids
50.4 - Tracheostomy Speaking Valve

o Part 2

150.2 - Osteogenic Stimulator
160.7 - Electrical Nerve Stimulators
160.12 - Neuromuscular Electrical Stimulation (NMES)
160.13 - Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)
160.17 - L-Dopa

o Part 3

170.1 - Institutional and Home Care Patient Education Programs
170.2 - Melodic Intonation Therapy
170.3 - Speech Pathology Services for the Treatment of Dysphagia
180 – Nutrition

o Part 4

230.8 - Non-implantable Pelvic Flood Electrical Stimulator
240.7 - Postural Drainage Procedures and Pulmonary Exercises
270.1 -Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds
270.4 - Treatment of Decubitus Ulcers
280.3 - Mobility Assisted Equipment (MAE)
280.4 - Seat Lift
280.13 - Transcutaneous Electrical Nerve Stimulators (TENS)
290.1 - Home Health Visits to A Blind Diabetic

- Pub. 100-08 PROGRAM INTEGRITY MANUAL

o Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.4.1.1 - Linking LCD and NCD ID Numbers to Edits

o Chapter 13 - Local Coverage Determinations

13.5.1 - Reasonable and Necessary Provisions in LCDs

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

- CORFs - See chapter 12 of this manual and also Pub. 100-04, chapter 5;
- SNF - See chapter 8 of this manual and also Pub. 100-04, chapter 6, for SNF claims/billing;
- HHA - See chapter 7 of this manual, and Pub. 100-04, chapter 10;
- GROUP THERAPY AND STUDENTS - See Pub. 100-02, chapter 15, §230;
- ARRANGEMENTS - Pub. 100-01, chapter 5, §10.3;

- COVERAGE is described in the Medicare Program Integrity Manual, Pub. 100-08, chapter 13, §13.5.1; and
- THERAPY CAPS - See Pub. 100-04, chapter 5, §10.2, for a complete description of this financial limitation.

C. General

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

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

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

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

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

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