CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 176	**Date: December 13, 2013**
	Change Request 8458

NOTE: Transmittal 175, dated December 6, 2013, is being rescinded and replaced by Transmittal 176, to reflect the correct manual heading for chapters 1 and 7 within the manual instruction. The correct heading is Medicare Benefit Policy Manual. All other information remains the same.

SUBJECT: Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius

I. SUMMARY OF CHANGES: In accordance with the *Jimmo v. Sebelius* Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant chapters of the program manual used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The following are some significant aspects of the manual clarifications now being issued:

- **No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care.** Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly.

- **Enhanced guidance on appropriate documentation.** Portions of the revised manual provisions now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case. Thus, though the *Jimmo* settlement does not explicitly reference documentation requirements, CMS has nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios. An example of this material appears in new section 30.2.2.1 of the revised chapter 8, in the guidelines for SNF coverage under Part A.

- **The Settlement Agreement.** The *Jimmo v. Sebelius* settlement agreement itself includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."** Rather, the intent is to clarify Medicare's

longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. By contrast, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of nonskilled personnel. As such, the revised manual material now being issued does not represent an expansion of coverage, but rather, provides clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the existing policy.

EFFECTIVE DATE: January 7, 2014
IMPLEMENTATION DATE: January 7, 2014

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/110.2/Inpatient Rehabilitation Facility Medical Necessity Criteria
R	1/110.3/Definition of Measurable Improvement
R	7/20.1.2/Determination of Coverage
R	7/30.1.2/Patient's Place of Residence
R	7/40.1/Skilled Nursing Care
R	7/40.1.1/General Principles Governing Reasonable and Necessary Skilled Nursing Care
R	7/40.1.2.1/Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status
R	7/40.1.2.2/Management and Evaluation of a Patient Care Plan
R	7/40.1.2.3/Teaching and Training Activities
R	7/40.1.2.7/Catheters
R	7/40.1.2.8/Wound Care
R	7/40.1.2.9/Ostomy Care
R	7/40.1.2.13/Venipuncture
R	7/40.1.2.14/Student Nurse Visits
R	7/40.1.2.15/Psychiatric Evaluation, Therapy, and Teaching
R	7/40.2/Skilled Therapy Services
R	7/40.2.1/General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy
R	7/40.2.2/Application of the Principles to Physical Therapy Services
R	7/40.2.3/Application of the General Principles to Speech-Language Pathology Services

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/40.2.4/Application of the General Principles to Occupational Therapy
R	7/40.2.4.1/Assessment
R	7/40.2.4.3/Illustration of Covered Services
R	8/Table of Contents
R	8/30/Skilled Nursing Facility Level of Care - General
R	8/30.2.1/Skilled Services Defined
R	8/30.2.2/Principles for Determining Whether a Service is Skilled
N	8/30.2.2.1/Documentation to Support Skilled Care Determinations
R	8/30.2.3/Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services
R	8/30.2.3.1/Management and Evaluation of a Patient Care Plan
R	8/30.2.3.2/Observation and Assessment of Patient's Condition
R	8/30.2.3.3/Teaching and Training Activities
R	8/30.3/Direct Skilled Nursing Services to Patients
R	8/30.4/Direct Skilled Therapy Services to Patients
R	8/30.4.1.1/General
R	8/30.4.1.2/Application of Guidelines
R	8/30.4.2/Speech -Language Pathology
R	8/30.4.3/Occupational Therapy
R	8/30.6/Daily Skilled Services Defined
R	8/30.7/Services Provided on an Inpatient Basis as a "Practical Matter"
R	15/Table of Contents
R	15/220/Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
R	15/220.1.1/Care of a Physician/Nonphysician Practitioner (NPP)
R	15/220.1.2/Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services
R	15/220.1.4/Requirement That Services Be Furnished on an Outpatient Basis
R	15/220.2/Reasonable and Necessary Outpatient Rehabilitation Therapy Services
R	15/220.3/Documentation Requirements for Therapy Services
R	15/230.1/Practice of Physical Therapy
R	15/230.2/Practice of Occupational Therapy
R	15/230.4/Services Furnished by a Therapist in Private Practice (TPP)
R	15/230.5/Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP)

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 176	Date: December 13, 2013	Change Request: 8458

NOTE: Transmittal 175, dated December 6, 2013, is being rescinded and replaced by Transmittal 176, to reflect the correct manual heading for chapters 1 and 7 within the manual instruction. The correct heading is Medicare Benefit Policy Manual. All other information remains the same.

SUBJECT: Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius

EFFECTIVE DATE: January 7, 2014
IMPLEMENTATION DATE: January 7, 2014

I. GENERAL INFORMATION

A. Background: In accordance with the *Jimmo v. Sebelius* Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant chapters of the program manual used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The following are some significant aspects of the manual clarifications now being issued:

- **No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care.** Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). For example, the longstanding SNF level of care regulations, specify that the

. . . restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need . . . skilled services . . . . [42 CFR 409.32(c)]

While the example included in this provision pertains specifically to skilled nursing services, CMS also wishes to clarify that the concept of skilled therapy services can similarly involve not only services that are restorative in nature (or "rehabilitative" therapy in the OPT setting) but, if certain standards are met, maintenance therapy as well:

- Restorative/Rehabilitative therapy. In evaluating a claim for skilled therapy that is restorative/rehabilitative (i.e., whose goal and/or purpose is to reverse, in whole or in part, a previous loss of function), it would be entirely appropriate to consider the beneficiary's potential for improvement from the services. CMS notes that such a consideration must always be made in the IRF setting where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered.

- Maintenance therapy. Even if no improvement is expected, under the SNF, HH, and OPT coverage standards, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective

maintenance program to maintain the patient's current condition or prevent or slow further deterioration. Skilled maintenance therapy may be covered when the particular patient's special medical complications or the complexity of the therapy procedures require skilled care.

Accordingly, these revisions to Pub. 100-02, Medicare Benefit Policy Manual clarify that a beneficiary's lack of restoration potential cannot serve as the basis for denying coverage in this context. Rather, such coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met). Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

The Medicare policy has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly. Therefore, denial notices should contain an accurate summary of the reason for denial, which should be based on the beneficiary's need for skilled care and not be based on lack of improvement for a beneficiary who requires skilled maintenance nursing services or therapy services as part of a maintenance program in the SNF HH, or OPT settings.

In Pub. 100-02 (the Manual within which all revisions were made by CR8458), the revised chapter 15, section 220 specifically discusses Part B coverage under the OPT benefit. In that chapter, both rehabilitative and maintenance therapy are addressed. Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. A "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." No mention of improving the patient's condition is noted within the MP definition.

- **Enhanced guidance on appropriate documentation.** Portions of the revised manual provisions now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case. Thus, even though the terms of the *Jimmo* settlement do not include an explicit reference to documentation requirements as such, CMS has nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios. An example of this material appears in new section 30.2.2.1 of the revised chapter 8, in the guidelines for SNF coverage under Part A.

CMS notes that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains stable" as being *insufficiently explanatory* to establish coverage). Rather, as indicated previously, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received—which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Further, as noted in the discussion of OPT coverage under Part B in chapter 15, section 220.3.D, care must be taken to assure that documentation justifies the necessity of the services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

In the case of maintenance therapy, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally or with the assistance of non-therapists, including unskilled caregivers.

- **The Settlement Agreement.** The *Jimmo v. Sebelius* settlement agreement itself includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."** Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, the revised manual material now being issued does not represent an expansion of coverage, but rather, provides clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the existing policy.

B. Policy: This Change Request updates Pub. 100-02, Medicare Benefit Policy Manual to clarify key components of SNF, IRF, HH, and OPT coverage requirements pursuant to the settlement agreement in the case of *Jimmo vs. Sebelius*. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8458.1	Contractors and providers shall review and be aware of the SNF, IRF, HH, and OPT manual revisions as they pertain to coverage requirements.	X											Hospital, IRF, Providers, SNF

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8458.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	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:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Anthony Hodge, anthony.hodge@cms.hhs.gov, Bill Ullman, 410-786-5667 or william.ullman@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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

Medicare Benefit Policy Manual

Chapter 1 - Inpatient Hospital Services Covered Under Part A

110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the post-admission physician evaluation described in section 110.1.2, the overall plan of care described in section 110.1.3, and the admission orders described in section 110.1.4) must demonstrate a reasonable expectation that the following criteria were met <u>at the time of admission</u> to the IRF:

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.

3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program that is defined in section 110.2.2 at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, as defined in section 110.3, and if such improvement can be expected to be made within a prescribed period of time. *The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard.*

4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in section 110.2.5.

110.3 - Definition of Measurable Improvement

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient's admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care *or return to his or her prior level of functioning*. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and an inter-disciplinary team approach to care (as defined in section 110.2.2). Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. Since in most instances the goal of an IRF stay is to enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.

CMS notes that as evidenced by the criteria established above, an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.

Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

20.1.2 - Determination of Coverage

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3113.1.B, HHA-203.1.B

The intermediary's decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR 484.55 or a medical record of the individual patient. Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care. *Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.*

30.1.2 - Patient's Place of Residence

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3117.1.B, HHA-204.1.B

A patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution meets the requirements of §§1861(e)(1) or 1819(a)(1) of the Act. Included in this group are hospitals and skilled nursing facilities, as well as most nursing facilities under Medicaid. (See the Medicare State Operations Manual, §2166.)

Thus, if a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered their residence. When a patient remains in a participating SNF following their discharge from active care, the facility may not be considered their residence for purposes of home health coverage.

A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during an episode of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home, or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. The requirements of homebound must be met at each location (e.g., considerable taxing effort etc.).

A. Assisted Living Facilities, Group Homes, and Personal Care Homes

An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients:

- Diagnostic and therapeutic services for medical diagnosis;
- Treatment;
- Care of *injured,* disabled or sick persons;
- Rehabilitation services or *other skilled services needed to maintain a patient's current condition or to prevent or slow further deterioration; or*
- Skilled nursing care or related services for patients who require medical or nursing care.

If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

If it is determined that the services furnished by the home health agency are duplicative of services furnished by an assisted living facility (also called personal care homes, group homes, etc.) when provision of such care is required of the facility under State licensure requirements, claims for such services should be denied under §1862(a)(1)(A) of the Act. Section 1862(a)(1)(A) excludes services that are not necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member from Medicare coverage. Services to people who already have access to appropriate care from a willing caregiver would not be considered reasonable and necessary to the treatment of the individual's illness or injury.

Medicare coverage would not be an optional substitute for the services that a facility is required to provide by law to its patients or where the services are included in the base contract of the facility. An individual's choice to reside in such a facility is also a choice to accept the services it holds itself out as offering to its patients.

B. Day Care Centers and Patient's Place of Residence

The current statutory definition of homebound or confined does not imply that Medicare coverage has been expanded to include adult day care services.

The law does not permit an HHA to furnish a Medicare covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to the home. Section 1861(m) of the Act stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence

used as the individual's home. A licensed/certified day care center does not meet the definition of a place of residence.

C. State Licensure/Certification of Day Care Facilities

Section 1861(m) of the Act, an adult day care center must be either licensed or certified by the State or accredited by a private accrediting body. State licensure or certification as an adult day care facility must be based on State interpretations of its process. For example, several States do not license adult day care facilities as a whole, but do certify some entities as Medicaid certified centers for purposes of providing adult day care under the Medicaid home and community based waiver program. It is the responsibility of the State to determine the necessary criteria for "State certification" in such a situation. A State could determine that Medicaid certification is an acceptable standard and consider its Medicaid certified adult day care facilities to be "State certified." On the other hand, a State could determine Medicaid certification to be insufficient and require other conditions to be met before the adult day care facility is considered "State certified".

D. Determination of the Therapeutic, Medical or Psychosocial Treatment of the Patient at the Day Care Facility

It is not the obligation of the HHA to determine whether the adult day care facility is providing psychosocial treatment, but only to assure that the adult day care center is licensed/certified by the State or accrediting body. The intent of the law, in extending the homebound exception status to attendance at such adult day care facilities, recognizes that they ordinarily furnish psychosocial services.

40.1 - Skilled Nursing Care

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1, HHA-205.1

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury as discussed in §40.1.1, below, and must be intermittent as discussed in §40.1.3. *Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.*

40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1, HHA-205.1

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a

registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the home health benefit.

Skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation, including 42 C.F.R. 409.32.

Some services may be classified as a skilled nursing service on the basis of complexity alone *(*e.g., intravenous and intramuscular injections or insertion of catheters*)* and*,* if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. *If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service.* However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. *A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.*

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers.

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician has

determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each episode, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- *the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and*
- *the patient/caregiver's response to the skilled services provided, and*
- *the plan for the next visit based on the rationale of prior results,*
- *a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,*
- *the complexity of the service to be performed, and*
- *any other pertinent characteristics of the beneficiary or home*

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the

patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- *Patient tolerated treatment well*
- *Caregiver instructed in medication management*
- *Continue with POC*

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

EXAMPLE 1:

The presence of a plaster cast on an extremity generally does not indicate a need for skilled nursing care. However, the patient with a preexisting peripheral vascular or circulatory condition might need skilled nursing care to observe for complications, monitor medication administration for pain control, and teach proper skin care to preserve skin integrity and prevent breakdown. *The documentation must support the severity of the circulatory condition that requires skilled care. The clinical notes for each home health visit should document the patient's skin and circulatory examination as well as the patient and/or caregiver application of the educational principles taught since the last visit. The plan for the next visit should describe the skilled services continuing to be required.*

EXAMPLE 2:

The condition of a patient, who has irritable bowel syndrome or is recovering from rectal surgery, may be such that he or she can be given an enema safely and effectively only by a nurse. If the enema were necessary to treat the illness or injury, then the visit would be covered as a skilled nursing visit. *The documentation must support the skilled need for the enema, and the plan for future visits based on this information.*

EXAMPLE *3*:

Giving a bath does not ordinarily require the skills of a nurse and, therefore, would not be covered as a skilled nursing service unless the patient's condition is such that the bath could be given safely and effectively only by a nurse (as discussed in §30.1 above).

EXAMPLE *4*:

A patient with a well-established colostomy absent complications may require assistance changing the colostomy bag because they cannot do it themselves and there is no one else to change the bag. Notwithstanding the need for the routine colostomy care, *changing* the *colostomy bag* does not become a skilled nursing service when the nurse provides it.

EXAMPLE *5*:

A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The HHA has taught the family to perform the dressing changes. The HHA continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as the patient requires it.

EXAMPLE *6*:

A physician has ordered skilled nursing visits for a patient with a hairline fracture of the hip. *The home health record must document the reason skilled services are required and why the* nursing visits *are* reasonable and necessary for treatment of the patient's hip injury.

EXAMPLE *7*:

A physician has ordered skilled nursing visits for teaching of self-administration and self-management of the medication regimen for a patient*, newly diagnosed,* with diabetes mellitus *in* the *home health plan of care. Each visit's documentation must describe the patient's progress in this activity*.

EXAMPLE *8*:

Following a cerebrovascular accident (CVA), a patient has an in-dwelling Foley catheter because of urinary incontinence, and is expected to require the catheter for a long and indefinite period. *The medical condition of the patient must be described and documented to support the need for nursing skilled services in the home health plan of care.* Periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper *catheter* care would be covered as long as they are reasonable and necessary, although the patient is stable*, even if* there is an expectation that the care will be needed for a long and indefinite period. *However, at every home health visit, the patient's current medical condition must be described and there must be documentation to support the need for continued skilled nursing services.*

EXAMPLE *9*:

A patient with advanced multiple sclerosis undergoing an exacerbation of the illness needs skilled teaching of medications, measures to overcome urinary retention, and the establishment of a program designed to minimize the adverse impact of the exacerbation. *The clinical notes for each home health visit must describe why skilled nursing services were required.* The skilled nursing care *received by* the patient would be covered despite the chronic nature of the illness.

EXAMPLE *10*:

A patient with malignant melanoma is terminally ill, and requires skilled observation, assessment, teaching, and treatment. The patient has not elected coverage under Medicare's hospice benefit. *The documentation should describe the goal of the skilled nursing intervention, and at each visit the services provided should support that goal.* The skilled nursing care that the patient requires would be covered, notwithstanding that the condition is terminal, because the *documentation and description must support that the needed* services *required* the skills of a nurse.

40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's *clinical condition and/or* treatment regimen *has* stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Information from the patient's *home health record must document the rationale that demonstrates that* there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. *Such signs and symptoms* as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these *signs and symptoms* are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. However, observation and assessment by a nurse is not reasonable and necessary *for* the treatment of the illness or injury where *fluctuating signs and symptoms* are part of a longstanding pattern of the patient's condition which *has* not *previously required a* change *in* the *prescribed* treatment.

EXAMPLE 1:

A patient with atherosclerotic heart disease with congestive heart failure requires observation by skilled nursing personnel for signs of decompensation or adverse effects resulting from *newly* prescribed medication. Skilled observation is needed to determine whether the *new* drug regimen should be modified or whether other therapeutic measures

should be considered until the patient's *clinical condition and/or* treatment regimen *has* stabilized. *The clinical notes for each home health visit should reflect the deliberations and their outcome.*

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including a revascularization procedure (bypass). The incision area is showing signs of potential infection, (e.g., heat, redness, swelling, drainage) and the patient has elevated body temperature. *For each home health visit, the clinical notes must demonstrate that the skilled* observation and monitoring is required.

EXAMPLE 3:

A patient was hospitalized following a heart attack. *Following* treatment *he was* discharged home. Because it is not known whether *increasing* exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated *in the patient's home. The patient's necessity for skilled observation must be documented at each home health visit* until the patient's *clinical condition and/or* treatment regimen *has* stabilized.

EXAMPLE 4:

A frail 85-year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the HHA for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed. *The patient's necessity for skilled observation and treatment must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.*

EXAMPLE 5:

A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta-blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmia. Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized. *The patient's necessity for skilled observation must be documented at each home health visit, until the clinical condition and/or patient's treatment regimen has stabilized.*

EXAMPLE 6:

A patient with hypertension suffered dizziness and weakness. The physician found that the blood pressure was too low and discontinued the hypertension medication. Skilled

observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range. *The patient's necessity for skilled observation must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.*

EXAMPLE 7:

A patient has chronic non-healing skin ulcers, Diabetes Mellitus Type I, and spinal muscular atrophy. In the past, the patient's wounds have deteriorated, requiring the patient to be hospitalized. Previously, a skilled nurse has trained the patient's wife to perform wound care. The treating physician orders a new episode of skilled care, at a frequency of one visit every 2 weeks to perform observation and assessment of the patient's skin ulcers to make certain that they are not worsening. This order is reasonable and necessary because, although the unskilled family caregiver has learned to care for the wounds, the skilled nurse can use observation and assessment to determine if the condition is worsening.

40.1.2.2 - Management and Evaluation of a Patient Care Plan

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.2, HHA-205.1.B.2

Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential *unskilled* care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility. Although a properly instructed person could perform any of the required services, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until *nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury until the patient recovers. Where nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury, skilled*

nursing care would not be considered reasonable and necessary, and the management and evaluation of the care plan would not be considered a skilled service.

EXAMPLE 2:

An aged patient with a history of mild dementia is recovering from pneumonia which has been treated at home. The patient has had an increase in disorientation, has residual chest congestion, decreased appetite, and has remained in bed, immobile, throughout the episode with pneumonia. While the residual chest congestion and recovery from pneumonia alone would not represent a high risk factor, the patient's immobility and increase in confusion could create a high probability of a relapse. In this situation, skilled oversight of the *unskilled* services would be reasonable and necessary pending the elimination of the chest congestion and resolution of the persistent disorientation to ensure the patient's medical safety. *For this determination to be made, the home health documentation must describe the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of a registered nurse in order to ensure that essential unskilled care is achieving its purpose.* Where visits by a licensed nurse are not needed to observe and assess the effects of the *unskilled* services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary to treat the illness or injury.

EXAMPLE 3:

A physician orders one skilled nursing visit every 2 weeks and three home health aide visits each week for bathing and washing hair for a patient whose recovery from a CVA has left him with residual weakness on the left side. The cardiovascular condition is stable and the patient has reached the maximum restoration potential. There are no underlying conditions that would necessitate the skilled supervision of a licensed nurse in assisting with bathing or hair washing. The skilled nursing visits are not necessary to manage and supervise the home health aide services and would not be covered.

40.1.2.3 - Teaching and Training Activities

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.3, HHA-205.1.B.3

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary. ***The reason why the training was unsuccessful should be documented in the record.*** Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the patient are to be considered. Where the teaching constitutes reinforcement, an analysis of the patient's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the patient returns home. Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

EXAMPLE 1:

A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent. The physician has ordered teaching of self-injection and management of insulin, signs, and symptoms of insulin shock, and actions to take in emergencies. The *education is* reasonable and necessary to the treatment of the illness or injury*, and the teaching services and the patient/caregiver responses must be documented.*

EXAMPLE 2:

A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition*, to recognize* signs and symptoms of adverse reactions to new medications, and *to follow the* necessary dietary restrictions. After it becomes apparent that the patient remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing care for further teaching would not be reasonable and necessary, since the patient has demonstrated an inability to

be taught. *The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses. The health record should also describe the reason for the failure of the educational attempts.*

EXAMPLE 3:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years and there is no change in the patient's physical or mental status that would require re-teaching. The skilled nursing visits would not be considered reasonable and necessary since the patient has a longstanding history of being able to perform the service.

EXAMPLE 4:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years because the patient has recently lost the use of the dominant hand and must be retrained to use the other hand. Skilled nursing visits to re-teach self-administration of the insulin would be reasonable and necessary. *The patient's response to teaching must be documented at each home health visit, until the patient has learned how to self-administer.*

EXAMPLE 5:

A patient recovering from pneumonia is being sent home requiring I.V. infusion of antibiotics four times per day. The patient's spouse has been shown how to administer the drug during the hospitalization and has been told the signs and symptoms of infection. The physician has ordered home health services for a nurse to teach the administration of the drug and the signs and symptoms requiring immediate medical attention.

EXAMPLE 6:

A spouse who has been taught to perform a dressing change for a post-surgical patient may need to be re-taught wound care if the spouse demonstrates improper performance of wound care. *The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.*

NOTE: There is no requirement that the patient, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care.

Teaching and training activities that require the skills of a licensed nurse include, but **are not limited to**, the following:

1. Teaching the self-administration of injectable medications, or a complex range of medications;

2. Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;

3. Teaching self-administration of medical gases;

4. Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;

5. Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;

6. Teaching self-catheterization;

7. Teaching self-administration of gastrostomy or enteral feedings;

8. Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

9. Teaching bowel or bladder training when bowel or bladder dysfunction exists;

10. Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;

11. Teaching transfer techniques, e.g., from bed to chair, that are needed for safe transfer;

12. Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;

13. Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

14. Teaching prosthesis care and gait training;

15. Teaching the use and care of braces, splints and orthotics and associated skin care;

16. Teaching the preparation and maintenance of a therapeutic diet; and

17. Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

18. Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to radiation treatments)

40.1.2.7 - Catheters

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.7, HHA-205.1.B.7

Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally require skilled care once every 60-90 days and this frequency of service would be considered reasonable and necessary. However, where there are complications that require more frequent skilled care related to the catheter, such care would, with adequate documentation, be covered.

EXAMPLE: A patient who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to three additional visits per month for skilled observation and evaluation and/or catheter changes if the patient or caregiver reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the patient's family contacts the HHA because the patient has an elevated temperature, abdominal pain, and scant urine output. The nurse visits the patient and determines that the catheter is plugged and there are symptoms of a urinary tract infection. The nurse changes the catheter and contacts the physician to report findings and discuss treatment. The skilled nursing visit to change the catheter and to evaluate the patient would be reasonable and necessary to the treatment of the illness or injury. *The need for the skilled services must be documented.*

40.1.2.8 - Wound Care

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.8, HHA-205.1.B.8

Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. Coverage or denial of skilled nursing visits for

wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;

- Wounds with a drain or T-tube with requires shortening or movement of such drains;

- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;

- Recently debrided ulcers;

- Pressure sores (decubitus ulcers) with the following characteristics:

    - There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or

    - There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

      NOTE: Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);

- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;

- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);

- Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;

- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;

- Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

EXAMPLE 1:

A patient has a second-degree burn with full thickness skin damage on the back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services. *The home health record at each visit must document the need for the skilled nursing services.*

EXAMPLE 2:

A patient experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for proper treatment. *The home health record at each visit must document the need for the skilled nursing services.*

NOTE: This section relates to the direct, hands on skilled nursing care provided to patients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (See §40.1.2.1) or skilled teaching of wound care to the patient or the patient's family. (See §40.1.2.3.)

40.1.2.9 - Ostomy Care

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.9, HHA-205.1.B.9

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications. *The teaching services and the patient/caregiver responses must be documented.*

40.1.2.13 - Venipuncture

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.13, HHA-205.1.B.13

Effective February 5, 1998, venipuncture for the purposes of obtaining a blood sample can no longer be the sole reason for Medicare home health eligibility. However, if a beneficiary qualifies for home health eligibility based on a skilled need other than solely venipuncture (e.g., eligibility based on the skilled nursing service of wound care and

meets all other Medicare home health eligibility criteria), medically reasonable and necessary venipuncture coverage may continue during the 60-day episode under a home health plan of care.

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act specifically exclude venipuncture, as a basis for qualifying for Medicare home health services if this is the sole skilled service the beneficiary requires. However, the Medicare home health benefit will continue to pay for a blood draw if the beneficiary has a need for another qualified skilled service and meets all home health eligibility criteria. This specific requirement applies to home health services furnished on or after February 5, 1998.

For venipuncture to be reasonable and necessary:

1. The physician order for the venipuncture for a laboratory test should be associated with a specific symptom or diagnosis, or the documentation should clarify the need for the test when it is not diagnosis/illness specific. In addition, the treatment must be recognized (in the Physician's Desk Reference, or other authoritative source) as being reasonable and necessary to the treatment of the illness or injury for venipuncture and monitoring the treatment must also be reasonable and necessary.

2. The frequency of testing should be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. Even where the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.

3. *The home health record must document the rationale for the blood draw as well as the results.*

   Examples of reasonable and necessary venipuncture for stabilized patients include, but are not limited to those described below.

   a. Captopril may cause side effects such as leukopenia and agranulocytosis and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.

   b. In monitoring phenytoin (e.g., Dilantin) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight and it is therefore appropriate to monitor the level on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.

   c. Venipuncture for fasting blood sugar (FBS)

- An unstable insulin dependent or noninsulin dependent diabetic would require FBS more frequently than once per month if ordered by the physician.

- Where there is a new diagnosis or where there has been a recent exacerbation, but the patient is not unstable, monitoring once per month would be reasonable and necessary.

- A stable insulin or noninsulin dependent diabetic would require monitoring every 2-3 months.

d. Venipuncture for prothrombin

- Where the documentation shows that the dosage is being adjusted, monitoring would be reasonable and necessary as ordered by the physician.

- Where the results are stable within the therapeutic ranges, monthly monitoring would be reasonable and necessary.

- Where the results *remain* within nontherapeutic ranges, there must be *specific* documentation of *the* factors *that* indicate why continued monitoring is reasonable and necessary.

EXAMPLE: A patient with coronary artery disease was hospitalized with atrial fibrillation and subsequently discharged to the HHA with orders for anticoagulation therapy *as well as other skilled nursing care. If indicated,* monthly venipuncture to report prothrombin (protime) levels to the physician *would be reasonable and necessary even though* the patient's prothrombin time tests indicate essential stability. *The home health record must document the rationale for the blood draw as well as the results*.

40.1.2.14 - Student Nurse Visits

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.14, HHA-205.1.B.14

Visits made by a student nurse may be covered as skilled nursing care when the HHA participates in training programs that utilize student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care and must be performed under the general supervision of a registered or licensed nurse. The supervising nurse need not accompany the student nurse on each visit. *All documentation requirements must be fulfilled by student nurses.*

40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.15, HHA-205.1.B.15

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.

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 programs or receive outpatient mental health services, the intermediary 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 nonpsychiatric 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.*

40.2 - Skilled Therapy Services

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.2, HHA-205.2

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered*, assuming all other eligibility and coverage criteria have been met*, the skilled services must also be reasonable and necessary to the treatment of the

patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's *clinical* condition, those activities require the *specialized* skills*, knowledge, and judgment* of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the *specialized* skills*, knowledge, and judgment* of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient'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 therapist are needed to treat the illness or injury, or whether the services can be carried out by *unskilled* personnel.

A service that is ordinarily considered *unskilled* could be considered a skilled therapy service in cases *where* there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make *an unskilled* service into a skilled service.

Assuming all other eligibility and coverage criteria have been met, the skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and

b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. *The home health record must specify the purpose of the skilled service provided.*

1. Assessment, Measurement and Documentation of Therapy Effectiveness

To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which

allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

i. **Initial Therapy Assessment**

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.

- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

ii. **Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)**

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

- Where more than one discipline of therapy is being provided, at least once every 30 days, a qualified therapist from each of the disciplines must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. In multi-discipline therapy cases, the qualified therapist would reassess functional items (and measure and document) those which correspond to the therapist's discipline and care plan goals. In cases where more than one discipline of therapy is being provided, the 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

iii. **Reassessment prior to the 14th and 20th therapy visit**

- If a patient's course of therapy treatment reaches 13 therapy visits, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered 13th therapy service, functionally reassess the patient, and compare the resultant measurement to prior measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.

  - Similarly, if a patient's course of therapy treatment reaches 19 therapy visits, a qualified therapist (instead of an assistant) must provide the ordered 19th therapy service, functionally reassess, measure and document the effectiveness of therapy, or lack thereof.

  - When the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at exactly the 13th visit, the qualified therapist's visit can occur after the 10th therapy visit but no later than the 13th visit. Similarly, in rural areas or if documented exceptional circumstances exist, the qualified therapist's visit can occur after the 16th therapy visit but no later than the 19th therapy visit.

  - Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof close to but no later than the 13th and 19th therapy visit. The 13th and 19th therapy visit timepoints relate to the sum total of therapy visits from all therapy disciplines. In multi-discipline therapy cases, the qualified therapist would reassess functional items and measure those which correspond to the therapist's discipline and care plan goals.

  - Therapy services provided after the 13th and 19th visit (sum total of therapy visits from all therapy disciplines), are not covered until:

    - The qualified therapist(s) completes the assessment/measurement/documentation requirements.

    - The qualified therapist(s) determines if the goals of the plan of care have been achieved or if the plan of care may require updating. If needed, changes to therapy goals or an updated plan of care is sent to the physician for signature or discharge.

    - If the measurement results do not reveal progress toward therapy goals and/or do not indicate that therapy is effective, but therapy continues, the qualified therapist(s) must document why the

physician and therapist have determined therapy should be continued.

c. Services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy. *Unskilled* individuals without the supervision of a therapist can perform those services.

d. Assuming all other eligibility and coverage requirements have been met, in order for therapy services to be covered, one of the following three conditions must be met:

1. The skills of a qualified therapist are needed to restore patient function:

    - To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician of the patient's restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements.

    - Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.

    - Therapy is not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury, under this condition. However, if the criteria for maintenance therapy described in (3) below is met, therapy could be covered under that condition.

2. The patient's *clinical* condition requires *the specialized skills, knowledge, and judgment of* a qualified therapist to establish *or design* a maintenance program, *related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation,*

    - *For patients receiving rehabilitative/restorative therapy services, if the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, the expectation is that the development of that maintenance program would occur during* the last visit(s) for *rehabilitative/*restorative treatment. The goals of a maintenance program would be to maintain *the patient's current* functional status or to prevent *or slow further deterioration*.

- *Necessary periodic* reevaluations *by a qualified therapist* of the beneficiary and maintenance program *are* covered if the specialized skills*, knowledge, and judgment* of a qualified therapist *are required*.

- Where a maintenance program is not established until after the rehabilitative*/restorative* therapy program has been completed, or where there was no rehabilitative*/restorative therapy* program*, and the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, such services* would be considered reasonable and necessary for the treatment of the patient's condition *in order to ensure the effectiveness of the treatment goals and ensure medical safety. When the development of a maintenance program could not be accomplished during the last visits(s) of rehabilitative/restorative treatment, the therapist must document why the maintenance program could not be developed during those last rehabilitative/restorative treatment visit(s).*

- When designing or establishing a maintenance program, the qualified therapist must teach the patient or the patient's family or caregiver's necessary techniques, exercises or precautions as necessary to treat the illness or injury. *The instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program is covered if the specialized skills, knowledge, and judgment of a qualified therapist are required.* However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., home health aides) are not billable as visits since the HHA is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.

3. The skills of a qualified therapist *(not an assistant)* are needed to perform maintenance therapy:

   Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized

assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered.

Further, under the standard set forth in the previous paragraph, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

e. The amount, frequency, and duration of the services must be reasonable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each episode, this includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- *the history and physical exam pertinent to the day's visit , (including the response or changes in behavior to previously administered skilled services) and*
- *the skilled services applied on the current visit, and*
- *the patient/caregiver's immediate response to the skilled services provided, and*
- *the plan for the next visit based on the rationale of prior results.*

Clinical notes should be written such that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- *Patient tolerated treatment well*
- *Caregiver instructed in medication management*
- *Continue with POC*

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

When the skilled service is being provided to either maintain the patient's condition or prevent or slow further deterioration, the clinical notes must also describe:

- *A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,*
- *the complexity of the service to be performed, and*
- *any other pertinent characteristics of the beneficiary or home.*

40.2.2 - Application of the Principles to Physical Therapy Services

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled physical therapy services applies the principles in §40.2.1 to specific physical therapy services about which questions are most frequently raised.

A. Assessment

Assuming all other eligibility and coverage requirements have been met, 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.

As described in section 40.2.1(b), at defined points during a course of therapy, the qualified physical therapist (instead of an assistant) must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of the therapy

in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

B. Therapeutic Exercises

Therapeutic exercises, which require the skills of a qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment constitute skilled physical therapy, when the criteria in §40.2.1(d) above are met.

C. Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to materially improve *or maintain* the patient's ability to walk *or prevent or slow further deterioration of the patient's ability to walk*. Gait evaluation and training which is furnished to a patient whose ability to walk has been impaired by a condition other than a neurological, muscular, or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore *or maintain* function *or to prevent or slow further deterioration*. Refer to §40.2.1(d)(1) for the reasonable and necessary coverage criteria associated with restoring patient function.

EXAMPLE 1:

A physician has ordered gait evaluation and training for a patient whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the beneficiary's gait, establish a gait training program, and provide the skilled services necessary to implement the program would be covered. *The patient's response to therapy must be documented. At appropriate intervals (see above), the qualified therapist must assess the patient with objective measurements of function.*

EXAMPLE 2:

A patient who has had a total hip replacement is ambulatory but demonstrates weakness and is unable to climb stairs safely. Physical therapy would be reasonable and necessary to teach the patient to climb and descend stairs safely. *Once the patient has reached the goal of climbing and descending stairs safely, additional therapy services are no longer required, and thus would not be covered.*

EXAMPLE 3:

A patient who has received gait training has reached their maximum restoration potential, and the physical therapist is teaching the patient and family how to safely perform the activities that are a part of the maintenance program. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a

therapist) would be covered since they are needed to establish the program (refer to §40.2.1(d)(2)). *The patient's and caregiver's understanding and implementation of the maintenance program must be documented. After the establishment of the maintenance program, any further visits would need to document why the skilled services of a physical therapist are still required.*

D. Range of Motion

Only a qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy.

Range of motion exercises constitute skilled physical therapy only if they are part of an active treatment for a specific disease state, illness, or injury that has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored). *Unskilled* individuals may provide range of motion exercises unrelated to the restoration of a specific loss of function often safely and effectively. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by *unskilled* persons do not constitute skilled physical therapy.

However, if the criteria in §40.2.1(d)(3) are met, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, and then the services would be covered.

E. Maintenance Therapy

Where services that are required to maintain *the patient's current* function *or to prevent or slow further deterioration are of such complexity* and *sophistication that* the *skills* of a *qualified* therapist *are* required *to perform* the *procedure* safely and effectively, the services would be covered physical therapy services. *Further, where the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled, such services would be covered physical therapy services.* Refer to §40.2.1(d)(3).

EXAMPLE 4:

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

EXAMPLE 5:

A Parkinson's patient or a patient with rheumatoid arthritis who has not been under a restorative physical therapy program may require the services of a physical therapist to

determine what type of exercises are required to maintain the patient's present level of function *or to prevent or slow further deterioration.* The initial evaluation of the patient's needs, the designing of a maintenance program appropriate to *the patient's* capacity and tolerance and *to* the treatment objectives of the physician, the instruction of the patient, family or caregivers to carry out the program safely and effectively, and such reevaluations as may be required by the patient's condition, would constitute skilled physical therapy. *Each component of this process must be documented in the home health record.*

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out alone or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session) the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.

F. Ultrasound, Shortwave, and Microwave Diathermy Treatments

These treatments must always be performed by or under the supervision of a qualified physical therapist and are skilled therapy.

G. Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths

Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications. *There must be clear documentation in the home health record, of the special medical complications that describe the need for the skilled services provided by the therapist.*

H. Wound Care Provided Within Scope of State Practice Acts

If wound care falls within the auspice of a 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. However, such visits in this specific situation would be a covered therapy service *when there is documentation in the home health record that* the skills of a therapist are required to perform the service. *The patient's response to therapy must be documented*.

40.2.3 - Application of the General Principles to Speech-Language Pathology Services

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled speech-language pathology services applies the principles to specific speech-language pathology services about which questions are most frequently raised. *Coverage of speech-language pathology services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled speech-language pathology services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified speech-language pathologist are necessary.*

As described in §40.2.1(b), at defined points during a course of therapy, the qualified speech-language pathologist must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

1. The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders), and rehabilitation potential. Reevaluation would be considered reasonable and necessary only if the patient exhibited:

    - A change in functional speech or motivation;
    - Clearing of confusion; or
    - The remission of some other medical condition that previously contraindicated speech-language pathology services.

    Where a patient is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy and cannot be billed as a separate visit.

2. The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed towards specific speech/voice production.

3. Speech-language pathology would be covered where *a skilled* service can only be provided by a speech-language pathologist and where it is reasonably expected that the *skilled* service will improve*, maintain, or prevent or slow further deterioration in* the patient's ability to carry out *communication or feeding* activities.

4. The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a patient toward speech-

language communication goals in the plan of care would be covered speech-language pathology.

5. The services of a speech-language pathologist to train the patient, family, or other caregivers to augment the speech-language communication, treatment, to establish an effective maintenance program*, or carry out a safe and effective maintenance program when the particular patient's special medical complications require the skills of a qualified therapist (not an assistant) to perform a therapy service that would otherwise be considered unskilled or the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedures,* would be covered speech-language pathology services.

6. The services of a speech-language pathologist to assist patients with aphasia in rehabilitation of speech and language skills are covered when needed by a patient.

7. The services of a speech-language pathologist to assist patients with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a patient.

40.2.4 - Application of the General Principles to Occupational Therapy

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.2.D, HHA-205.2.D

The following discussion of skilled occupational therapy services applies the principles to specific occupational therapy services about which questions are most frequently raised. *Coverage of occupational therapy services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled occupational therapy services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified occupational therapist are necessary.*

40.2.4.1 - Assessment

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Assuming all other eligibility and coverage requirements are met, the skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential or to develop and/or implement an occupational therapy program are covered when they are reasonable and necessary because of the patient's condition.

As described in §40.2.1(b), at defined points during a course of therapy, the qualified occupational therapist (instead of an assistant) must perform the ordered therapy service visit, assess the *patient's* function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of therapy in

the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

40.2.4.3 - Illustration of Covered Services

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.2.D.3, HHA-205.2.D.3

EXAMPLE 1:

A physician orders occupational therapy for a patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting, and bathing. The occupational therapist will establish goals for the patient's rehabilitation (to be approved by the physician), and will undertake teaching techniques necessary for the patient to reach the goals. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. *Such visits would be considered covered when the skills of a therapist are required to perform the services. The patient's needs in response to therapy must be documented.*

EXAMPLE 2:

A physician has ordered occupational therapy for a patient who is recovering from a CVA. The patient has decreased range of motion, strength, and sensation in both the upper and lower extremities on the right side. In addition, the patient has perceptual and cognitive deficits resulting from the CVA. The patient's condition has resulted in decreased function in activities of daily living (specifically bathing, dressing, grooming, hygiene, and toileting). The loss of function requires assistive devices to enable the patient to compensate for the loss of function and maximize safety and independence. The patient also needs equipment such as himi-slings to prevent shoulder subluxation and a hand splint to prevent joint contracture and deformity in the right hand. The services of an occupational therapist would be necessary to:

- Assess the patient's needs;
- Develop goals (to be approved by the physician);
- Manufacture or adapt the needed equipment to the patient's use;
- Teach compensatory techniques;
- Strengthen the patient as necessary to permit use of compensatory techniques; and
- Provide activities that are directed towards meeting the goals governing increased perceptual and cognitive function.

Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. *Such visits would be considered covered therapy services when the skills of a therapist are required to perform the services. The patient's needs, course of therapy and response to therapy must be documented.*

Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

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30 - Skilled Nursing Facility Level of Care - General

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132, SNF-214

Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

- The patient requires these skilled services on a daily basis (see §30.6); and

- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)

- The services *delivered are* reasonable and necessary for the treatment of a patient's illness or injury, i.e., *are* consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of *some* skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

In reviewing *claims for* SNF services to determine whether the level of care requirements are met, the intermediary *or Medicare Administrative Contractor (MAC)* first considers whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements are not addressed. *See section 30.2.2.1 for a discussion of the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. Additional material on documentation appears in the various clinical scenarios that are presented throughout these level of care guidelines.*

Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care.

Eligibility for SNF Medicare A coverage has not changed with the inception of PPS. However, the skilled criteria and the medical review process have changed slightly. For Medicare to render payment for skilled services provided to a beneficiary during a SNF Part A stay, the facility must complete an MDS.

EXAMPLE: Even though the irrigation of a suprapubic catheter may be a skilled nursing service, daily irrigation may not be "reasonable and necessary" for the treatment of a patient's illness or injury.

30.2.1 - Skilled Services Defined

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and

- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

30.2.2 - Principles for Determining Whether a Service is Skilled

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132.1.B, SNF-214.1.B

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

- The intermediary *or MAC* considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

EXAMPLE: When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's

potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel. (See §30.5.)

- A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and *notes as well as* nursing or therapy notes.

EXAMPLE:

Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds. *The documentation needs to support the severity of the circulatory condition that requires skilled care (see section 30.2.2.1).*

- In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.

EXAMPLE:

An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan. *As discussed in section 30.2.2.1 below, the medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services.*

- The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

EXAMPLE:

A primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such services are obviously necessary.

- The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

30.2.2.1 – Documentation to Support Skilled Care Determinations
(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—

- *Skilled involvement is required in order for the services in question to be furnished safely and effectively; and*

- *The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.*

Such determinations would be made from the perspective of the patient's condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. Thus, when a service appears reasonable and necessary from that perspective, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved. However, if it becomes apparent at some point that the goal set for the patient is no longer a reasonable one, then the treatment goal itself should be promptly and appropriately modified to reflect this, and the patient should then be reassessed to determine whether the treatment goal as revised continues to require the provision of skilled services. By the same token, the ***treatment goal itself*** *cannot be modified retrospectively, e.g., when it becomes apparent that the initial treatment goal of restoration is no longer a reasonable one, the provider cannot retroactively alter the initial goal of treatment from restoration to maintenance. Instead, it would make such a change on a prospective basis only.*

Although the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the means by which a provider would be able to establish and a contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.

It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed.

Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary's need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment's purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no "improvement" to evaluate. For example, when skilled services are necessary to maintain the patient's current condition, the documentation would need to substantiate that the services of skilled personnel are, in fact, required to achieve this goal. Similarly, establishing that a maintenance program's services are reasonable and necessary would involve regularly documenting the degree to which the program's treatment goals are being accomplished. In situations where the maintenance program is performed to maintain the patient's current condition, such documentation would serve to demonstrate the program's effectiveness in achieving this goal. When the maintenance program is intended to slow further deterioration of the patient's condition, the efficacy of the services could be established by documenting that the natural progression of the patient's medical or functional decline has been interrupted. Assessments of all goals must be performed in a frequent and regular manner so that the resulting documentation provides a sufficient basis for determining the appropriateness of coverage.

Therefore the patient's medical record must document as appropriate:

- *The history and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services);*
- *The skilled services provided;*
- *The patient's response to the skilled services provided during the current visit;*
- *The plan for future care based on the rationale of prior results.*
- *A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;*
- *The complexity of the service to be performed;*
- *Any other pertinent characteristics of the beneficiary.*

The documentation in the patient's medical record must be accurate, and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:

- *Patient tolerated treatment well*
- *Continue with POC*
- *Patient remains stable*

Such phraseology does not provide a clear picture of the results of the treatment, nor the "next steps" that are planned. Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded so that all concerned can follow the results of the provided services.

30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

The following sections describe specific examples of skilled nursing or skilled rehabilitation services.

A3-3132.1.C, SNF-214.1.C

30.2.3.1 - Management and Evaluation of a Patient Care Plan

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.1.C.1, SNF-214.1.C.1

The development, management, and evaluation of a patient care plan, based on the physician's orders *and supporting documentation*, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.

The patient's clinical record may not always specifically identify "skilled planning and management activities" as such. Therefore, in this limited context, if the documentation of the patient's overall condition substantiates a finding that the patient's medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel, it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely

potential for serious complications without skilled management, as illustrated in the following Examples.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until *such time as skilled care is no longer required in coordinating* the patient's treatment regimen, even though the individual services involved are supportive in nature and do not require skilled nursing personnel. *The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the stabilization of the patient's medical condition and safety.*

EXAMPLE 2:

An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety. *The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

30.2.3.2 - Observation and Assessment of Patient's Condition

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.1.C.2, SNF-214.1.C.2

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify

and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's *condition* is essentially stabilized.

EXAMPLE 1:

A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.*

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

EXAMPLE 3:

A patient has undergone hip surgery and has been transferred to a SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, *or* skin breakdown, is both reasonable and necessary. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

EXAMPLE 4:

A patient has been hospitalized following a heart attack, and following treatment but before mobilization, is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient's treatment regimen is essentially stabilized. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.*

EXAMPLE 5:

A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly.

The patient is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

EXAMPLE 6:

A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition, to maintain the patient's current condition, or to prevent or slow further deterioration in the patient's condition.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode. "Reasonable probability" means that a potential complication or further acute episode was a likely possibility.

Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.

Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services are reasonable and necessary. However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these characteristics are part of a longstanding pattern of the patient's waxing and waning condition which by themselves do not require skilled services and there is no attempt to change the treatment to resolve them.

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders are

precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented.

30.2.3.3 - Teaching and Training Activities

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.1.C.3, SNF-214.1.C.3

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.

The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training. The medical record should also describe the reason for the failure of any educational attempts, if applicable.

EXAMPLE:

A newly diagnosed diabetic patient is seen in order to learn to self-administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions. Even though the patient voices understanding of the nutritional principles of his diabetic diet, he expresses dissatisfaction with his food choices and refuses to comply with the education he is receiving. This refusal continues, notwithstanding efforts to counsel the

patient on the potentially adverse consequences of the refusal and to suggest alternative dietary choices that could help to avoid or alleviate those consequences. The patient's response to the recommended treatment plan as well as to all educational attempts is documented in the medical record.

30.3 - Direct Skilled Nursing Services to Patients

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.2, SNF-214.2

Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual's potential for improvement from nursing care, but rather on the beneficiary's need for skilled care.

A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances. In such instances, skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services.

A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by an unskilled person, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

Some examples of direct skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;

- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

30.4 - Direct Skilled *Therapy* Services to Patients

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.1.C, SNF-214.1.C

The following sections contain examples and guidelines concerning direct skilled therapy services to patients, including skilled physical therapy, occupational therapy, and speech/language pathology therapy.

Coverage for such skilled therapy services does not turn on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

If all other requirements for coverage under the SNF benefit are met, such skilled therapy services are covered when an individualized assessment of the patient's clinical condition

demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services.

30.4.1.1 - General

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;

- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially 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; *or, the services must require the skills of a qualified therapist (not an assistant) for the* ***performance*** *of a safe and effective maintenance program.* ***NOTE:*** *See Section E. Maintenance Therapy for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program.*

- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,

- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

EXAMPLE 1:

An 80-year old, previously ambulatory, post-surgical patient has been bed-bound for 1 week, and, as a result, had developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy to restore lost functions, those services are reasonable and necessary *and must be documented in the medical record (see §30.2.2.1).*

EXAMPLE 2:

A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary *and must be documented in the medical record (see §30.2.2.1).*

Physical therapy services are not reasonable and necessary and would not be covered if the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results.

Some SNF inpatients do not require skilled physical therapy services but do require services, which are routine in nature. *When* services can be *safely and effectively* performed by supportive personnel*, such as* aides or nursing personnel, without the supervision of a physical therapist*, they do not constitute skilled physical therapy. Additionally,* services involving activities for the general good and welfare of the patient (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

30.4.1.2 - Application of Guidelines

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132.3.A.2, SNF-214.3.A.2

Some of the more common skilled physical therapy modalities and procedures are:

A. Assessment

The skills of a physical therapist are required for the ongoing assessment of a patient's rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measurements of range of motion, strength, balance, coordination, endurance, and functional ability.

B. Therapeutic Exercises

Therapeutic exercises, which must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient.

C. Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality often require the skills of a qualified physical therapist.

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking *can be* appropriately provided by supportive personnel, e.g., aides or nursing personnel, and *would* not *necessarily* require the skills of a physical therapist. Thus, such services are not *inherently* skilled. *However, see §30.2.2. for the specific circumstances in which an ordinarily nonskilled service can nevertheless be considered skilled. Documentation of the patient's condition in the medical record must describe the circumstances which delineate the need for skilled rather than unskilled services during gait training*.

D. Range of Motion

Only the qualified physical therapist may perform range of motion tests and, therefore, such **tests** are skilled physical therapy. Range of motion **exercises** constitute skilled physical therapy only if they are part of active treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost, the degree to be restored and the impact on mobility and/or function).

Generally, range of motion exercises which are not related to the restoration of a specific loss of function may be provided safely by supportive personnel, such as aides or nursing personnel, and *as such would* not *necessarily* require the skills of a physical therapist. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by aides or nursing personnel would not be considered skilled care. *However, see §30.2.2. for the specific circumstances in which an ordinarily nonskilled service can nevertheless be considered skilled. Documentation of the patient's condition in the medical record must describe the circumstances which delineate the need for skilled rather than unskilled services during range of motion training.*

E. Maintenance Therapy

Therapy services in connection with a maintenance program are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because

it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services do not constitute a covered level of care.

A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct supervision of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct supervision of a therapist, the service cannot be regarded as a skilled therapy service even when a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

However, even though it would not otherwise require the skills of a therapist, the performance of a maintenance program may nevertheless require such skills under certain circumstances. Specifically, skilled therapy services are necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

If the specialized knowledge and judgment of a qualified therapist are required, the establishment or design of a maintenance program by a qualified therapist, the instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program, and the necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are considered skilled therapy services, to the extent provided by regulation.

EXAMPLE: A patient with Parkinson's disease may require the services of a physical therapist to determine the type of exercises that are required to maintain his present level of function. The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, would constitute skilled physical therapy *and must be documented in the medical record (see §30.2.2.1).*

While a patient is receiving a skilled physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out independently or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further *skilled therapy services are needed*, i.e., by the end of the last skilled session, the physical therapist will have already designed *any* maintenance program required and instructed the patient or supportive personnel in the carrying out of the program.

F. Ultrasound, Shortwave, and Microwave Diathermy Treatments

These modalities must always be performed by or under the supervision of a qualified physical therapist.

G. Hot Packs, Infra-Red Treatments, Paraffin Baths, and Whirlpool Baths

Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications. *There must be clear documentation in the medical record of the special medical complications that describe the need for the skilled therapy provided by the therapist.*

30.4.2 - Speech -Language Pathology

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

See §30.4.1.2.E. Maintenance Therapy for the specific circumstances in which speech-language pathology therapy is appropriate in connection with a maintenance program.

30.4.3 - Occupational Therapy

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)
A3-3132.3.C, SNF-214.3.C

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

See §30.4.1.2.E. Maintenance Therapy for the specific circumstances in which occupational therapy is appropriate in connection with a maintenance program.

30.6 - Daily Skilled Services Defined

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

EXAMPLE:

A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient's skilled status is based on a restorative program, medical evidence must *be documented* to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to "daily" skilled services. However, arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a "daily basis." To meet this requirement, the patient must actually **need** skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is **furnished** each day, unless the patient's medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the "daily basis" requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but **when** they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the "daily basis" requirement for SNF coverage would not be met.

30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A3-3132.6, SNF-214.6

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the intermediary *or MAC* considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a “practical matter,” daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be *ineffective* because the patient would have insufficient assistance at home to reside there safely.

EXAMPLE: A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, because insufficient supervision and assistance could not be arranged for the patient in his home. In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

Medicare Benefit Policy Manual
Chapter 15 – Covered Medical and Other Health Services

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(Rev. 176, 12-13-13)

220.1.1 - Care of a Physician/Nonphysician *Practitioner* (NPP)

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

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

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

A. Definitions

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

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

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

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

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

laws allow it and their personal professional training is judged by Medicare contractors as sufficient to provide to the beneficiary skills equivalent to a therapist for that service.

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

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

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

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

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

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)

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

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

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

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

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

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

PROVIDERS of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services. To qualify as providers of services, these providers must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to

charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made. Note that the word PROVIDER in sections 220 and 230 is not used to mean a person who provides a service, but is used as in the statute to mean a facility or agency such as rehabilitation agency or home health agency.

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

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

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

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

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

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

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

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

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

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

B. References

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

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

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

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

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

- Pub.100-01 GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT
    - Chapter 1- General Overview

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

- Pub. 100-02, MEDICARE BENEFIT POLICY MANUAL

  - Ch 6 - Hospital Services Covered Under Part B

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

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

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

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

  10 - Comprehensive Outpatient Rehabilitation Facility (CORF) Services Provided by Medicare
  20 - Required and Optional CORF Services
  20.1 - Required Services
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  30 - Rules for Provision of Services
  30.1 - Rules for Payment of CORF Services
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  40.1 - Physicians' Services
  40.2 - Physical Therapy Services
  40.3 - Occupational Therapy Services
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- Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL

- Part 1

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

- Part 2

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

- Part 3

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

- Part 4

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

- Pub. 100-08 PROGRAM INTEGRITY MANUAL

  - Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

  3.4.1.1 - Linking LCD and NCD ID Numbers to Edits

  - Chapter 13 - Local Coverage Determinations

13.5.1 - Reasonable and Necessary Provisions in LCDs

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

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

C. General

Therapy services are a covered benefit in §§1861(g), 1861(p), and 1861(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.

220.1.1 - Care of a Physician/Nonphysician *Practitioner* (NPP)

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Although there is *no Medicare requirement for an order, when* documented in the medical record, *an order* provides evidence that the patient *both needs therapy services and* is under the care of a physician. *The* certification requirements are met when the physician certifies the plan of care. If the signed order includes a plan of care (see essential requirements of plan in §220.1.2), no further certification of the plan is required. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.

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

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

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

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

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

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

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

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

- A physician/NPP (consultation with the treating physical therapist, occupational therapist, or speech-language pathologist is recommended. Only a physician may establish a plan of care in a CORF;

- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or
- The speech-language pathologist who will provide the speech-language pathology services.

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

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

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

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

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

The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24, 410.61, and 410.105(c) (for CORFs)). (See §220.3 for further documentation requirements):

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

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment

in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. *Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care. If the expected episode of care is short, for example therapy is expected to be completed in 4 to 6 treatment days, the long term and short term goals may be the same. In other instances measurable goals may not be achievable, such as when treatment in a particular setting is unexpectedly cut short (such as when care is transferred to another therapy provider) or when the beneficiary suffers an exacerbation of his/her existing condition terminating the current episode;* documentation should state the clinical reasons progress cannot be shown. The functional impairments identified and expressed in the long term treatment goals must be consistent with those used in the claims-based functional reporting, using nonpayable G-codes and severity modifiers, for services furnished on or after January 1, 2013. (Reference: 42CFR410.61 and 42CFR410.105 (for CORFs*).*

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

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

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

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

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

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

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

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

C. Changes to the Therapy Plan

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

- The physician/NPP;

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

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

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

220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

Reference: 42CFR410.60

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

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

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

Therapy services are payable when furnished in the home at the same physician fee schedule *payment rates* as in other outpatient settings. Additional expenses incurred by providers *of outpatient therapy* due to travel to *the beneficiary are* not covered.

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

220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

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

A. General

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

actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

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

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

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

B. Reasonable and Necessary

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

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:
    - Medicare manuals (such as this manual and Publications 100-03 and 100-04),
    - Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: http://www.cms.hhs.gov/mcd, and
    - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are

not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional. *Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. (For additional guidance, see subsection D below related to Maintenance Programs.)*

- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, *the contractor* shall presume that such services were properly supervised when required. However, this presumption is rebuttable and, if in the course of processing *a claim, the contractor* finds that services *were not* furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.

- While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis *cannot* be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See *items* C *and D* for descriptions of *covered* skilled services*; and*

- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

NOTE: Claims for therapy services denied because they are not considered reasonable and necessary *under §1862(a)(1)(A)* of the Act and*, for services furnished on or after January 1, 2013, those denied as a result of application of the therapy caps under §1833(g)(1) or (g)(3) are subject* to consideration under the waiver of liability provision in §1879 of the Act.

C. Rehabilitative Therapy

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

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

- Evaluations *and* reevaluations*;*

- Establishment of treatment goals specific to the patient's disability or dysfunction and designed to specifically address each problem identified in the evaluation;

- Design of a plan of care addressing the patient's disorder, including establishment of procedures to obtain goals, determining the frequency and intensity of treatment;

- Continued assessment and analysis during implementation of the services at regular intervals;

- Instruction leading to establishment of compensatory skills;

- Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system); and

- *Training of patient* and family to augment rehabilitative treatment*. Training* of staff and family should be ongoing *throughout* treatment and instructions modified intermittently *as* the patient's status changes.

Rehabilitative therapy *requires* the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. (See *definition of therapist in* section 220.*A* of this chapter*.) Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative* therapy *services.*

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

Rehabilitative therapy is not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary *and generalized* weakness, which may follow a brief period of bed rest following surgery) *that* could reasonably be expected to improve spontaneously as the

patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered.

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

D. Maintenance Programs

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

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

- ***Establishment or design of maintenance programs.*** *If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.*

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

maintain the patient's current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures. Unlike coverage for rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient's potential for improvement from the therapy.

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

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

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

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

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

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

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

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

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

EXAMPLE: *A patient with a long history of Multiple Sclerosis has difficulties transferring in and out of the wheelchair and maintaining range of motion (ROM) of the lower extremities (LEs) due to increased spasticity muscle tone since the most recent exacerbation episode of her Multiple Sclerosis. The beneficiary is unable to walk but is independent with the use of her wheelchair. The beneficiary needs to be able to safely transfer in and out of her wheelchair by herself or with the assistance of a family member or other caregiver(s). After an individualized assessment by the physical therapist, and given the patient's overall medical and physical condition, the skills of the physical therapist are required to instruct the patient and/or caregivers in proper techniques of wheelchair transfers and LE stretches due to the special medical complications from the progression of Multiple Sclerosis. When the physical therapist determines that the patient can carry out the transfers and stretching activities safely and effectively, either alone or with the assistance of the caregivers, the skills of the physical therapist are no longer necessary to furnish the maintenance therapy; and, the patient is discharged from PT.*

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

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

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

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

220.3 - Documentation Requirements for Therapy Services

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A. General

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

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

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

B. Documentation Required

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

- Evaluation and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;

- Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due.

- Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due. (See definitions in section 220 and descriptions in 220.3 D);

- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes);

- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

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

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

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

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

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

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

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

- Services require the skills of a therapist.

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

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

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

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

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

  <u>Needs of the Patient.</u> When a service is reasonable and necessary, the patient also needs the services. Contractors determine the patient's needs through

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

- Functional information included on claims as required.

  The clinician is required to document in the patient's medical record, using the G-codes and severity modifiers used in functional reporting, the patient's current, projected goal, and discharge status, as reported pursuant to functional reporting requirements for each date of service for which the reporting is required. See section 220.4 below for details on documenting G-code and modifiers.

C. Evaluation/Re-Evaluation and Plan of Care

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

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

<u>Evaluation</u> 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 body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;

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

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

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

  Activity Measure – Post Acute Care (AM-PAC)

  OPTIMAL by Cedaron through the American Physical Therapy Association

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

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

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

- Identification of durable medical equipment needed for this condition, and/or

- Identification of the number of medications the beneficiary is taking (and type if known); and/or

- If complicating factors (complexities) affect treatment, describe why or how. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but in some patients such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception to caps for necessary services. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient's condition as reported on a functional measurement tool may be so great as to suggest extended treatment is anticipated; and/or

- Generalized or multiple conditions. The beneficiary has, in addition to the primary condition being treated, another disease or condition being treated, or generalized musculoskeletal conditions, or conditions affecting multiple sites and these conditions will directly and significantly impact the rate of recovery; and/or.

- Mental or cognitive disorder. The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery; and/or.

- Identification of factors that impact severity including e.g., age, time since onset, cause of the condition, stability of symptoms, how typical/atypical are the symptoms of the diagnosed condition, availability of an intervention/treatment known to be effective, predictability of progress.

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

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

- Identification of whether beneficiary was treated for this same condition previously by the same therapy discipline (regardless of where prior services were furnished; and

- Record of a previous episode of therapy treatment from the same or different therapy discipline in the past year.

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

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

Documentation required to indicate beneficiary social support including, specifically,

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

- Who does beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode? (e.g., lives alone, spouse/significant other, child/children, other relative, unrelated person(s), personal care attendant), and

- Does the beneficiary require this outpatient therapy plan of care in order to return to a premorbid (or reside in a new) living environment, and

- Does the beneficiary require this outpatient therapy plan of care in order to reduce Activities of Daily Living (ADL) or Instrumental Activities of Daily Living or (IADL) assistance to a premorbid level or to reside in a new level of living environment (document prior level of independence and current assistance needs); and

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

- Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or

- Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or

- Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

- Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and

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

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

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

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

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

A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation.

The minutes for re-evaluation are documented in the same manner as the minutes for evaluation. Current Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code.

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

D. Progress Report

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

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

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

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

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

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

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

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

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

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

Progress Reports for Services Billed Incident to a Physician's Service. The policy for incident to services requires, for example, the physician's initial service, direct supervision of therapy services, and subsequent services of a frequency which reflect

his/her active participation in and management of the course of treatment (see section 60.1B of this chapter. Also, see the billing requirements for services incident to a physician in Pub. 100-04, chapter 26, Items 17, 19, 24, and 31.) Therefore, supervision and reporting requirements for supervising physician/NPPs supervising staff are the same as those for PTs and OTs supervising PTAs and OTAs with certain exceptions noted below.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;

- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's progress report; and

- Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.

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

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

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

- *In the case of rehabilitative therapy, the* patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

- *In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.*

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

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

E. Treatment Note

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

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

Documentation of each treatment shall include the following required elements:

- Date of treatment; and

- Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is

represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and

- Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, chapter 5, section 20.2 for description of billing timed codes; and

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

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

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

- Patient self-report;

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

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

230.1 - Practice of Physical Therapy

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A. General

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

B. Qualified Physical Therapist Defined

Reference: 42CFR484.4

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

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

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

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

- graduated from a CAPTE approved program in PT on or before December 31, 2009 (examination is not required); or,

- graduated on or before December 31, 2009, from a PT program outside the U.S. that is determined to be substantially equivalent to a U.S. program by a credentials evaluating organization approved by either the APTA or identified in 8 CFR 212.15(e) and also passed an examination for PTs approved by the state in which practicing.

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

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

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

- admitted to membership by the APTA; or

- admitted to registration by the American Registry of Physical Therapists; or

- graduated from a 4-year PT curriculum approved by a State Department of Education; or

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

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

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

C. Services of Physical Therapy Support Personnel

Reference: 42CFR 484.4

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

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

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

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

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

- 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

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

- they have graduated before January 1, 2008, from a 2 year college level program approved by the APTA; or

- on or before December 31, 1977, they were licensed or qualified as a PTA and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

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

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

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

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

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

D. Application of Medicare Guidelines to PT Services

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

230.2 - Practice of Occupational Therapy

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A. General

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

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

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

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

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

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

- The teaching of compensatory technique to improve the level of independence in the activities of daily living *or adapt to an evolving deterioration in health and function*, for example:

    - Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand;

    - Teaching an upper extremity amputee how to functionally utilize a prosthesis;

    - Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities as independently as possible; or

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

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

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

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

B. Qualified Occupational Therapist Defined
Reference: 42CFR484.4

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

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

the services. The education program for U.S. trained OTs is accredited by the Accreditation Council for Occupational Therapy Education (ACOTE). The requirements above apply to all OTs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

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

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

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

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

- on or before January 1, 2008, they graduated an OT program approved jointly by the American Medical Association and the AOTA, or

- they are eligible for the National Registration Examination of AOTA or the National Board for Certification in OT.

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

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

- graduated from an OT education program accredited as substantially equivalent to a U.S. OT education program by ACOTE, the World Federation of Occupational Therapists, or a credentialing body approved by AOTA; and

- passed the NBCOT examination for OT; and

- Effective January 1, 2010, are licensed or otherwise regulated, if applicable as an OT by the state in which practicing.

For outpatient OT services that are provided incident to the services of physicians/NPPs, the requirement for OT licensure does not apply; all other personnel qualifications do apply. The qualified personnel providing OT services incident to the services of a physician/NPP must be trained in an accredited OT curriculum. For example, a person

who, on or before December 31, 2009, graduated from an OT curriculum accredited by ACOTE and is eligible to take or has successfully completed the entry-level certification examination for OTs developed and administered by NBCOT, could provide Medicare outpatient OT services incident to the services of a physician/NPP if the physician assumes responsibility for the services according to the incident to policies. On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide OT services incident to the services of a physician/NPP.

C. Services of Occupational Therapy Support Personnel

Reference: 42CFR 484.4

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

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

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

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

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

- after January 1, 2010, they have also completed an education program accredited by ACOTE and passed the NBCOT examination for OTAs.

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

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

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

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

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

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

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

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

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

D. Application of Medicare Guidelines to Occupational Therapy Services

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

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

230.4 - Services Furnished by a Therapist in Private Practice (TPP)

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

A. General

See section 220 of this chapter for definitions. Therapist refers only to a qualified physical therapist, occupational therapist or speech-language pathologist. TPP refers to therapists in private practice (qualified physical therapists, occupational therapists and speech-language pathologists).

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

For purposes of this provision, a physician/NPP group practice is defined as one or more physicians/NPPs enrolled with Medicare who may bill as one entity. For further details on issues concerning enrollment, see the provider enrollment Web site at www.cms.hhs.gov/MedicareProviderSupEnroll and Pub. 100-08, Medicare Program Integrity Manual, chapter*15*, section *15.4.4.9*.

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

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

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

If therapists who have their own Medicare National Provider Identifier (NPI) are employed by therapist groups, physician/NPP groups, or groups that are not professional organizations, the requirement that therapy space be owned, leased, or rented may be satisfied by the group that employs the therapist. Each therapist employed by a group should enroll as a TPP.

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

When the therapist who has a Medicare NPI is employed in a physician's/NPP's office the services are ordinarily billed as services of the therapist, with the therapist identified on the claim as the supplier of services. However, services of the therapist who has a Medicare NPI may also be billed by the physician/NPP as services incident to the physician's/NPP's service. (See §230.5 for rules related to therapy services incident to a physician.) In that case, the physician/NPP is the supplier of service, the NPI of the supervising physician/NPP is reported on the claim with the service and all the rules for both therapy services and incident to services (§230.5) must be followed.

B. Private Practice Defined

Reference: **Federal Register** November, 1998, pages 58863-58869; 42CFR 410.38(b), 42CFR410.59, 42CFR410.60, 42CFR410.62

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

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

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

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

C. Assignment

Reference: Nov. 2, 1998 **Federal Register**, pg. 58863
See also Pub. 100-04 chapter 1, §30.2.

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

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

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

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

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

(Rev. 176, Issued: 12-13-13, Effective: 01-07-14, Implementation: 01-07-14)

References: §1861(s)(2)(A) of the Act
42 CFR 410.10(b)
42 CFR 410.26
Pub. 100-02, ch. 15, §60.

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

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

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

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

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

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

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

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

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

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

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

necessary therapy services even if they are performed or supervised by a physician/NPP or other qualified professional.

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