



Physician Services Version

KEY CONCEPTS OUTLINE

Module 10: Physicians Aren't the Only Ones that Can Expect Compensation; Non-Physician Practitioner Services

I. Scope of this Module

A. This module addresses Medicare coverage, billing and payment for the following types of non-physician practitioners:

1. Nurse Practitioners (NPs)
2. Physician Assistants (PAs)

B. For purposes of this module, the term "NPP" is used to refer to NPs and PAs.

II. Non-Physician Practitioners (NPPs)

A. Coverage of NPP Services

1. How NPP Services are Potentially Covered By Medicare

a. In general, there are three different ways under which Medicare will potentially cover NPP services.

(i) Separate Enrollment

(a) NPPs may separately enroll in Medicare and have their services covered independently of any physician service. <See *Medicare Benefit Policy Manual*, Chapter 15 §§ 190, 200, 210>

(b) As discussed below, the manner in which NPP services are billed and paid depends on how the services are performed.

(ii) "Incident To"

(a) NPP services may be covered under Medicare's so-called "incident to" coverage provisions. <*Medicare Benefit Policy Manual*, Chapter 15 § 60.2>

(iii) Split/Shared Services

(a) A split/shared service is a service where both an NPP and a physician see a patient. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.18>

2. Coverage of NPP Services for Separately Enrolled NPPs

a. In General

(i) NPPs who are separately enrolled in Medicare and issued a billing number may have his or her professional services compensated if they are legally authorized to provide services in the state where the services are performed. <See *Medicare Benefit Policy Manual*, Chapter 15 §§ 190 and 200>

(a) As discussed below, there are different enrollment requirements applicable to NPs and PAs.

b. Coverage for Separately Enrolled NPs

(i) In order for Medicare to cover the services of a separately enrolled NP, the following requirements must be satisfied:

(a) The "Licensure" Requirement

(1) The NP must be a registered professional nurse authorized to practice as a nurse practitioner under applicable state law. <42 CFR § 410.75(b); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(A)>

(b) The "Certification" Requirement

(1) The NP must be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. <42 CFR § 410.75(b); Medicare Benefit Policy Manual, Chapter 15 § 200(A)>

(2) Certifying Agencies – the following organizations are recognized national certifying bodies:

- a. American Academy of Nurse Practitioners,
- b. American Nurses Credentialing Center,

- c. Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses),
- d. National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties,
- e. AACN Certification Corporation,
- f. National Board on Certification of Hospice and Palliative Nurses, and
- g. Oncology Nurses Certification Corporation. < See *Medicare Benefit Policy Manual*, Manual, Chapter 15 § 200(A)>

(3) Exception to Certification Requirement

- a. NPs who meet the licensure requirement do not need to meet the certification requirement if the NP was enrolled in Medicare as a nurse practitioner on or before December 31, 2000. <42 CFR § 410.75(b); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(A)>

(c) The "Master's Degree" Requirement

- (1) After January 1, 2003, NPs enrolling for the first time are also required to have a Master's degree. <42 CFR § 410.75(b)(4); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(A)>

(d) The "Physician Services" Requirement

- (1) The services furnished by the NP must be of a type that would be covered if furnished by a physician. <42 CFR § 410.75(c); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(B)(1)>

(e) The "Scope of Practice" Requirement

- (1) The services furnished by the NP must be of a type that a NP is authorized to furnish under applicable state law. <42 CFR § 410.75(c)(1); Medicare Benefit Policy Manual, Chapter 15 § 200(B)(1)>

(f) The "Physician Collaboration" Requirement

- (1) The NP must practice in “collaboration” with an MD/DO. <42 CFR § 410.75(c)(3); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(D)>
 - (2) Collaboration is defined by Medicare as a process in which a NP works with one or more physicians to deliver health care services, with physician medical direction and appropriate supervision as required by state law. <42 CFR § 410.75(c)(3)(i); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(D)>
 - a. In the absence of state law governing collaboration, Medicare requires NPs to document their scope of practice and the relationships that the NP has with physicians to deal with issues outside their scope of practice. <42 CFR § 410.75(c)(3)(ii); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(D)>
 - (3) The collaborating physician does not need to be present with the NP when services are furnished or to make an independent evaluation of each patient who is seen by the NP. <42 CFR § 410.75(c)(3)(iii); See *Medicare Benefit Policy Manual*, Chapter 15 § 200(D)>
- c. Coverage for Separately Enrolled PA Services
- (i) In order for Medicare to cover the services of a separately enrolled PA, the following requirements must be satisfied:
 - (a) The “Licensure” Requirement
 - (1) The PA must be licensed by the state to practice as a physician assistant. <42 CFR § 410.74(c); See *Medicare Benefit Policy Manual*, Chapter 15 § 190(A)>
 - (b) The “Accreditation/Certification” Requirement
 - (1) The PA must meet one of the following conditions:
 - a. The PA must have graduated from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant, or

- b. The PA must have passed the national certification examination administered by the National Commission on Certification of Physician Assistants. <42 CFR § 410.74(c); See *Medicare Benefit Policy Manual*, Chapter 15 § 190(A)>

(c) The "Physician Services" Requirement

- (1) The services furnished by the PA must be of a type that would be covered if furnished by a physician. <42 CFR § 410.74(a)(1); See *Medicare Benefit Policy Manual*, Chapter 15 § 190(B)(1)>

(d) The "Scope of Practice" Requirement

- (1) The services furnished by the PA must be of a type that a PA is authorized to furnish under applicable state law. <42 CFR § 410.74(a)(2); See *Medicare Benefit Policy Manual*, Chapter 15 § 190(B)(1)>

(e) The "General Physician Supervision" Requirement

- (1) The PA's services must be furnished under the general supervision of a physician.
- (2) General supervision requires that PA services be performed under the overall direction and control of the physician. < See *Medicare Benefit Policy Manual*, Chapter 15 § 190(C)>
 - a. While the supervising physician must be immediately available to the PA for consult, this does not mean the supervising physician must be physically present when the PA is furnishing services. <42 CFR § 410.74(a)(2)>
 - b. Telephone consultations are permissible by Medicare unless prohibited by state law or regulation. < See *Medicare Benefit Policy Manual*, Chapter 15 § 190(C)>

(f) The "Employer Billing" Requirement

- (1) The PA's services must be billed by the PA's employer. <42 CFR § 410.74(a)(2); See *Medicare Benefit Policy Manual*, Chapter 15 § 190(D)>

(2) The employer may not be a group of PAs.

- a. However, the PA may have an ownership interest in the employer entity if the employer entity is otherwise eligible to enroll in Medicare (e.g., a physician group practice).

d. Billing for Separately Enrolled NPP Services

- (i) NPP services covered as the services of a separately enrolled NPP are billed under the NPP's NPI. <See *Medicare Benefit Policy Manual*, Chapter 15 § 200>
- (ii) In essence, the services are billed in the exact same manner as they would have been billed had the NPP been a physician.

e. Payment for Services Billed Under an Enrolled NPP's NPI

- (i) The Medicare allowable for services billed under an NPP's NPI is determined based on the lesser of 80% of the actual charge or 85% of the applicable Physician Fee Schedule amount. <42 CFR §§ 414.52(d), 414.56(c); See *Medicare Claims Processing Manual*, Chapter 12, §§ 110 and 120.1>

3. "Incident To" Coverage of NPP Services

a. Definition

- (a) "Incident to" coverage means that the NPP's services are covered as a component part in the diagnosis or overall course of treatment being furnished by a physician or other practitioner. < See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1>
- (b) For the incident to discussion, the term physician includes other practitioners such as nurse practitioners and physician assistants.

b. "Incident To" Coverage Requirements

(i) The "Integral, Although Incidental" Requirement

- (a) The "incident to" services must have been an "integral, although incidental" part of a physician's professional services in diagnosing or treating a Medicare beneficiary. <42 CFR § 410.26(b)(2); See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1>

(1) This means that:

- a. There must have been a “direct, personal, professional service” furnished by the physician to initiate the course of treatment, and
- b. There must be subsequent services provided by the physician of a frequency that reflects his or her continuing active participation in and management of the course of treatment. < See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1 (B)>
- c. However, the physician does not need to personally see the patient every time the patient sees the NPP. < See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1 (B)>

(ii) The “Direct Supervision” Requirement

- (a) “Incident to” services must be furnished under the “direct supervision” of a physician or NPP.

(1) What Constitutes Direct Supervision?

- a. Direct supervision in the office setting does not mean that a physician or NPP must be present in the same room when auxiliary personnel furnishes services. However, a physician/NPP must be present in the office suite and immediately available to provide assistance and direction. <42 CFR §§ 410.26(b)(5), 410.32(b)(3)(ii); See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1 (B)>
- b. The availability of the physician by telephone is not sufficient. < See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1(B)>
- c. CMS has never clearly defined the term “office suite.”

(2) Direct Supervision In a Group Practice Setting

- a. If the physician who initiated the course of treatment is a member of a group practice, another physician in the group may provide the direct supervision for incident to services. < See *Medicare Benefit Policy Manual*, Chapter 15 § 60.3)>

- b. However, effective January 1, 2016, the physician providing supervision MUST be the provider billing Medicare for the services, not the one that initiated treatment <42 CFR § 410.26(b)(5)>

(iii) The "Included in the Physician's Bill" Requirement

- (a) To be covered as "incident to" services, the services must be of a type that are commonly included in the bill of a physician/practitioner (or furnished without charge). <42 CFR § 410.26(b)(3); See *Medicare Benefit Policy Manual*, Chapter 15 § 60 (A)>

- (1) The implications of this requirement have always been somewhat unclear. Presumably, it simply means that the attending physician (i.e., the physician to whom the NPPs services are "incident to") must bill for the services ("incident to" billing is discussed below).

(iv) The "Physician Expense" Requirement

- (a) To be covered as "incident to" services, the NPP services must represent a direct financial expense to the physician or billing entity. <Medicare Benefit Policy Manual, Chapter 15 § 60.1(E)>

- (1) This means that the physician (or practice) must be paying for the services of the NPP. < See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1(A)>

- (2) However – the NPP need not be a "W-2" employee. "Incident to" coverage is also available for leased employees and independent contractors. <42 CFR § 410.26(a)(1); See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1(B)>

(v) The "Commonly Furnished in a Physician's Office" Requirement

- (a) To be covered as an "incident to" service, the service must be of a type that is commonly furnished in a physician's office or clinic. <42 CFR § 410.26(b)(4); See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1(A)>

(b) The "Institutional Patients" Limitation on "Incident To" Coverage

- (1) "Incident to" coverage is not available for services furnished in a hospital or skilled nursing facility or for services furnished (presumably in any setting) to a hospital or SNF

patient. <42 CFR §§ 410.26(b)(1), 410.26(a)(5); See *Medicare Benefit Policy Manual*, Chapter 15 § 60.1(B)>

(c) Provider-Based Clinics

- (1) Although not entirely clear, it appears that the “institutional patients” limitation precludes incident to coverage in a clinic (or any other entity) that is treated as “provider-based” for Medicare purposes.

(vi) The “Eligible Provider” Requirement

- (a) To be covered as an “incident-to” service, the provider providing that service must be eligible for payment under the Medicare program, meaning that they have not been excluded from the Program by the Office of Inspector General or had his or her Medicare enrollment revoked <42 CFR § 410.26(a)(1)>
- (b) Service must be within the scope of practice imposed by the licensure of the provider within the state in which they are practicing <42 CFR § 410.26(a)(1)>

c. Billing for “Incident To” NPP Services

- (i) NPP services furnished “incident to” the services of a physician are billed as follows:
- (a) When the “incident to” services were supervised by a physician other than the attending physician (i.e., the physician to whom the NPP’s services are “incident to”), the supervising physician’s NPI is reported in Item 24J. <Medicare Claims Processing Manual, Chapter 26 § 10.4, Item 24J>
- (1) Although not stated in the Claims Processing Manual, if the attending physician personally supervised the NPP, presumably, the attending physician’s NPI would be reported in Item 24J.
- (2) The group NPI should be reported in Item 33a when the attending physician is in a group practice. < *Medicare Claims Processing Manual*, Chapter 26 § 10.4, Item 33a>
- (ii) Interestingly, for “incident to” claims there is no way to tell from the claim itself that the services were actually furnished by a NPP rather than the attending physician.

d. Payment for "Incident To" NPP Services

- (i) Medicare pays for "incident to" services at the same rate that it would have paid for the services if the attending physician had personally furnished the services.

4. Split/Shared Services

a. Definition

- (i) A split/shared service is a service where both a NPP and a physician from the same group practice see a patient. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.18>

b. Coverage of Split/Shared" Services

- (i) Although not considered an "incident to" service, Medicare covers split/shared visits in a hospital if the NPP and physician are "from the same group practice" <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.18>

- (1) Although not entirely clear, it appears that only evaluation and management ("E/M") services qualify for coverage as a split/shared encounter.

- (ii) Billing for Split/Shared Encounters Furnished in a Hospital

- (a) Split/shared services are billed under the NPI of the practitioner who performed the substantive portion of the visit <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(B)>

- (1) The Substantive Portion is defined by CMS to be more than half the total time of the visit.

- (2) CMS considered CY 2022 and 2023 to be transitional years allowing the substantive portion to be determined by the key half the total time of the visit or the key components (MDM for CY 2023). In the 2024 Medicare Physician Fee Schedule Final Rule, CMS indicated that for CY 2024 the substantive portion may be determined by:

- a. More than half the total time of the visit; or

- b. Completely performs the medically appropriate history, or exam described in the code descriptor, or the medical

decision making (MDM) < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.18(B)(1)

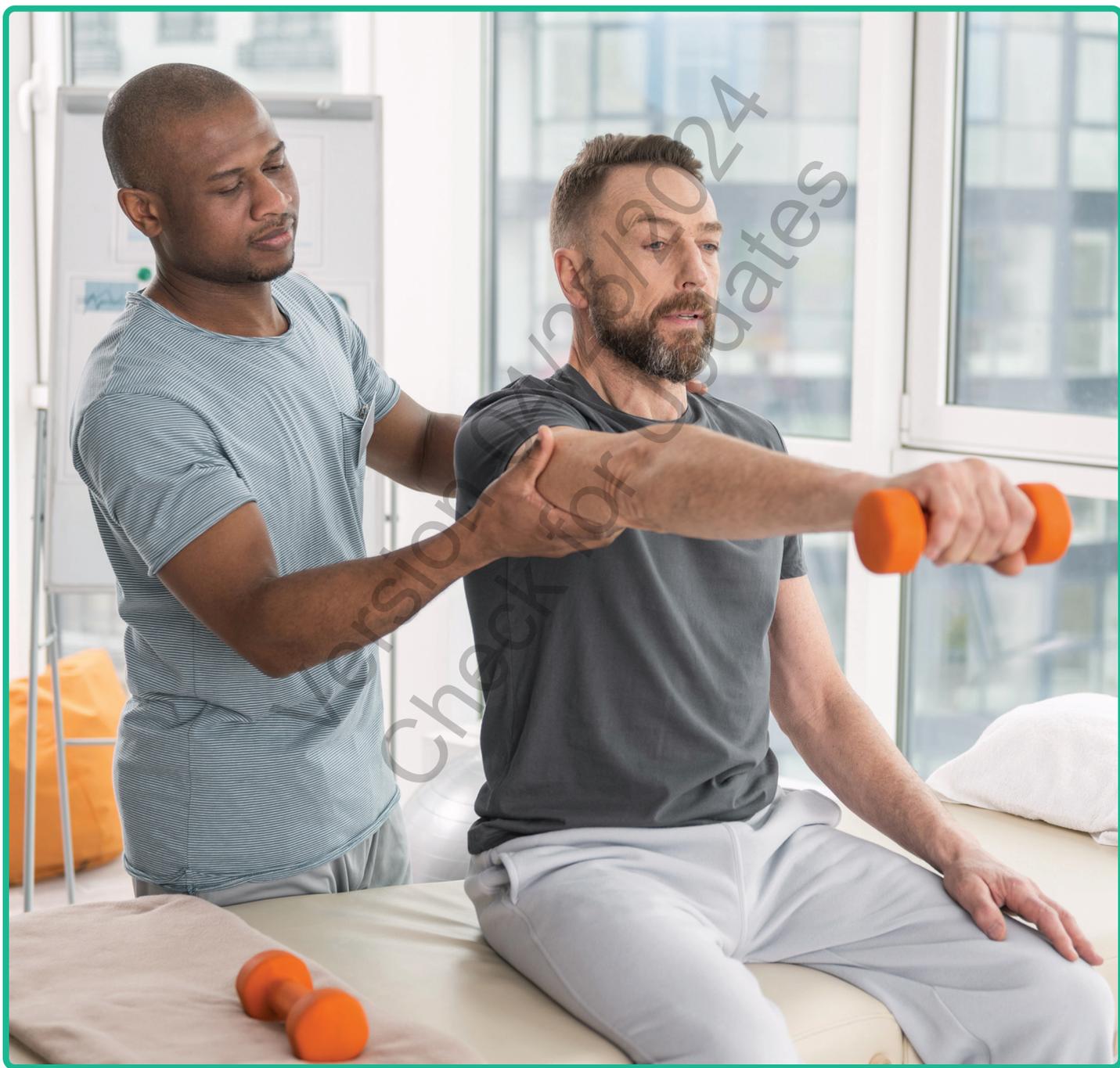
- (b) Eligible in a facility setting, which includes hospital inpatient, hospital outpatient, and emergency department settings. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.18(A)>

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Complying with Outpatient Rehabilitation Therapy Documentation Requirements



What's Changed?

CMS created 2 new therapy assistant service modifiers (page 7).

You'll find substantive content updates in dark red font.

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This fact sheet was collaboratively developed by the Medicare Learning Network® (MLN) and the Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Outreach & Education Task Forces to provide nationally-consistent education on topics of interest to health care providers.

In this fact sheet, “**we**” refers to CMS and “**you**” refers to the provider or supplier.

In this fact sheet we’ll discuss:

- Common outpatient rehabilitation therapy services’ CERT errors
- Medicare outpatient rehabilitation therapy documentation requirements

The CERT Program measures improper payments in the Medicare Fee-for-Service (FFS) Program and selects a random sample of Medicare FFS claims for review to determine if they were properly paid under Medicare coverage, coding, and billing rules. [Visit the CERT webpage for more information.](#)

Billing Part B Outpatient Therapy Services

Outpatient rehabilitation therapy includes Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services.

Medicare covers outpatient PT, OT, and SLP services when:

- Physician or Non-Physician Practitioner (NPP) certifies the “treatment plan,” called the Plan of Care (POC), ensuring:
 - Patient needs therapy services
 - POC is:
 - Established by a physician, NPP, or qualified therapist providing services
 - Reviewed periodically by a physician or NPP
 - Patient gets services under physician care
- POC certifying provider’s name and NPI is on the claim
- Providers meet medical necessity, documentation, and coding requirements

Definitions

Physician is a Doctor of Medicine, osteopathy, podiatric medicine, optometry (only for low vision rehabilitation).

NPP is a Physician Assistant (PA), Clinical Nurse Specialist (CNS), or Nurse Practitioner (NP).

Qualified Therapist includes a PT, OT, or SLP who meets regulatory qualifications as applicable, including state licensure or certification. Sections 230.1–230.3 of [Medicare Benefit Policy Manual Chapter 15](#) has more information.



Common Outpatient Rehabilitation Therapy CERT Errors

Error	Prevention
Missing certification and recertification(s): Physician’s, NPP’s, or therapist’s dated signature(s) approving the POC	Confirm physician or NPP certified the POC (and recertified it when appropriate) with their signature and date
Missing signature: Physician, NPP, or therapist who developed the POC and established treatment plan date	Ensure you add your dated signature and professional identification (for example, PT, OT)
Missing or incomplete POC	Create a complete POC that includes diagnoses, long-term goals, type, amount, frequency, and service(s) duration
Missing significant POC changes: Certifications and recertification(s)	Certify a significantly modified POC (physician or NPP signs and dates it)
Missing total time: For timed procedures and total active treatment time	Clearly document in 15-minute timed codes the total treatment time to support number of units and codes billed for each treatment day; document total active treatment time (including timed and untimed codes) in the patient’s medical record
Missing or incomplete initial evaluation	Document initial evaluation with your signature, professional identification (for example, PT, OT) and date you made the initial evaluation (see section 220.3 of Medicare Benefit Policy Manual, Chapter 15 for more information)
Missing or incomplete progress reports	Progress reports justify medical necessity and require information such as timing (at least once every 10 treatment days) and should include your signature, professional identification, and date (see section 220.3 of Medicare Benefit Policy Manual, Chapter 15 for more information)
Missing elements supporting medical necessity	See sections 220 and 230 of Medicare Benefit Policy Manual, Chapter 15 for more information

Note: If your MAC identifies a potential outpatient therapy Part B claim overpayment within 6 years of receiving the overpayment (generally referred to as the “look back period”), the provider must report and return all identified overpayments. See section 1128J(d) of the [Social Security Act](#) for more information.

Outpatient Rehabilitation Therapy Services Documentation

Written POC

The services must relate directly and specifically to a written treatment plan (also known as a POC or plan of treatment). You must establish the POC before treatment begins, with some exceptions. A physician, PT, OT, SLP, or an NPP may develop (written or dictated) a POC. Only a physician may establish a POC in a Comprehensive Outpatient Rehabilitation Facility (CORF).

At a minimum, the POC must have:

- Diagnoses
- Long-term treatment goals
- **Rehabilitation therapy service types:** PT, OT, or SLP, when appropriate
 - Describe type as a specific treatment or intervention type
- **Therapy amount:** Number of treatment sessions per day
- **Therapy frequency:** Number of treatment sessions per week
- **Therapy duration:** Total number of weeks or treatment sessions

Include the signature and professional identity of the person who established the POC and the date it was established. Document the physician's or NPP's written or verbal approval, and any significant or long-term goal change (for example, the physician or NPP treating a new condition) to the already certified POC. Each POC should offer the most effective and efficient treatment and balance appropriate resources to provide the best possible outcomes.



Initial POC Certification

The physician's or NPP's signature and date on a correctly written POC, with or without an order, satisfies the certification requirement during the POC or 90 calendar days from the initial treatment date, whichever is less. Include the initial evaluation indicating the POC treatment need.

The physician or NPP certifies the initial POC with a dated signature or verbal order within 30 days from the first day of treatment, including evaluation. The physician or NPP must sign and date verbal orders within 14 days.

Recertification

Sign recertifications, documenting the need for continued or modified therapy whenever a significant POC modification becomes evident or at least every 90 days after treatment starts.

Complete recertification sooner when the plan duration is less than 90 days unless a certification delay occurs. We allow delayed certification when the physician or NPP completes certification and includes a delay reason. We accept certifications without justification up to 30 days after the due date. Recertification is timely when dated during initial POC or within 90 calendar days of initial POC, whichever is less.

Billing Procedure Units

When reporting "untimed service units" HCPCS codes (procedure is undefined by specific time frame), report **1** in the unit field (for example, therapy evaluations, group therapy, and supervised modalities HCPCS codes).

We define some 15-minute patient contact HCPCS codes as direct (1-on-1) time spent in patient contact. The number of units for these timed codes reported per discipline for each date, regardless of the number of different treatments provided, is determined by total timed codes treatment time.

Document total minutes under timed codes in the patient's medical record for each service date to support the number of units and codes billed. Also, report total active treatment service minutes, including timed and untimed procedures or modalities.

Therapy Modifier Requirements

All outpatient therapy service claims must report a therapy modifier (GP, GO, or GN) with the HCPCS code to show the treatment plan discipline (PT, OT, or SLP). Certain HCPCS codes require certain therapy modifiers.

In 2019, we created 2 new therapy assistant services modifiers:

- **CQ Modifier:** Outpatient physical therapy services furnished, in whole or in part, by a physical therapist assistant
- **CO Modifier:** Outpatient occupational therapy services furnished, in whole or in part, by an occupational therapy assistant

As of January 1, 2020, each outpatient therapy services claim, in whole or in part, must include these modifiers for Occupational Therapy Assistant (OTA) or Physical Therapy Assistant (PTA) services.

See [Reduced Payment for PT and OT Services Furnished In Whole or In Part by a PTA or OTA](#) for more information.

We allow providers to bill a 15-minute timed service without the CQ and CO modifier when a PTA and OTA provides patient care, independent from the PT or OT. The PT or OT must meet Medicare timed service billing requirements and not include independent PTA or OTA minutes. They must provide more than the 15-minute midpoint (that is, 8 minutes or more—also known as the 8-minute rule). Any minutes the PTA or OTA provides in these situations doesn't matter for Medicare billing purposes.

We allow providers to bill a 15-minute unit with the CQ or CO modifier and 1, 15-minute unit without the CQ or CO modifier in billing situations where there's 2, 15-minute units left to bill when the PT or OT and the PTA or OTA each provide 9–14 minutes of the same service when the total time is at least 23 minutes and no more than 28 minutes.

Correctly Using Timed & Untimed Codes

When you provide only 1, 15-minute timed HCPCS code per day, we don't allow billing of that service if you did it for less than 8 minutes. When providing more than 1 unit of service, the initial and subsequent service must each total at least 15 minutes, and the last unit may count as a full-service unit if it has at least 8 minutes of additional services. Don't count all treatment minutes per day to 1 HCPCS code if more than 15 minutes of 1, or you provided other services.

If a therapist provides 4 distinct, separate 8-minute treatments (32 treatment minutes total), don't report 4, 15-minute treatment units on the claim. In this case, you may report only 2 units (at least 23 minutes but less than 38 minutes). You may report a third unit when you provide a total of 38–52 minutes; and you may bill a fourth unit if you provide at least 53 but less than 68 treatment minutes. Don't report units on the claim that exceed the total timed codes' treatment minutes.

If you report both timed and untimed codes on the same claim, don't count time spent on untimed-code services toward the timed-code services.

Section 20.2 of [Medicare Claims Processing Manual, Chapter 5](#) has more information about HCPCS coding requirements, including examples correctly showing 15-minute codes when providing 1 or multiple therapy services, procedures, and or modalities per day.

Resources

- [Local Coverage Determinations](#)
- [Medicare Program Integrity Manual, Chapter 12](#)
- [Medicare Benefit Policy Manual, Chapter 12, sections 20 and 30](#)
- [Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, section 10.3](#)
- [Medicare Program Integrity Manual, Chapter 3, section 3.3.2.4](#)

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The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Forces are independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors.

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Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

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See §60.2 for coverage of services performed by nurse-midwives incident to the service of physicians.

F. Place of Service

There is no restriction on place of service. Therefore, nurse-midwife services are covered if provided in the nurse-midwife's office, in the patient's home, or in a hospital or other facility, such as a clinic or birthing center owned or operated by a nurse-midwife.

G. Assignment Requirement

Assignment is required.



190 - Physician Assistant (PA) Services

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

Effective for services rendered on or after January 1, 1998, any individual who is participating under the Medicare program as a physician assistant for the first time may have his or her professional services covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish PA services in the State where the services are performed. PAs who were issued billing provider numbers prior to January 1, 1998 may continue to furnish services under the PA benefit.

See the Medicare Claims Processing Manual, Chapter 12, "Physician and Nonphysician Practitioners," §110, for payment methodology for PA services. Payment is made under assignment only.

A. Qualifications for PAs

To furnish covered PA services, the PA must meet the conditions as follows:

1. Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or
2. Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
3. Be licensed by the State to practice as a physician assistant.

B. Covered Services

Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General

The services of a PA may be covered under Part B, if all of the following requirements are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets all the PA qualifications,
- They are performed under the general supervision of an MD/DO;
- The PA is legally authorized to perform the services in the state in which they are performed; and
- They are not otherwise precluded from coverage because of one of the statutory exclusions.



2. Incident To

If covered PA services are furnished, services and supplies furnished incident to the PA's services may also be covered if they would have been covered when furnished incident to the services of an MD/DO, as described in §60.



3. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B physician assistant covered services, the physician assistant may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the physician assistant's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.



4. Types of PA Services That May Be Covered

State law or regulation governing a PA's scope of practice in the State in which the services are performed applies. A/B MACs (B) should consider developing lists of covered services. Also, if authorized under the scope of their State license, PAs may

furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.

Examples of the types of services that PAs may provide include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

See §60.2 for coverage of services performed by PAs incident to the services of physicians.



5. Services Otherwise Excluded From Coverage

The PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a PA's scope of practice under State law.



C. Physician Supervision

The physician supervision requirement under Medicare law is met under the circumstances as follows:

Medicare Part B covers a PA's services only if the PA performs the services in accordance with state law and state scope of practice rules for PAs in the state in which the PA's professional services are furnished. Any state laws and scope of practice rules that describe the required practice relationship between physicians and PA's, including explicit supervisory or collaborative practice requirements, describe a form of supervision for purposes of the PA benefit category under section 1861(s)(2)(K)(i) of the Act. For states with no explicit state law and scope of practice rules regarding physician supervision of PA's services, physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physician/s when furnishing professional services.



D. Direct Billing and Payment

Effective January 1, 2022, direct billing and payment for PA services may be made to the PA.

E. Assignment

Assignment for PA services is mandatory.

**200 - Nurse Practitioner (NP) Services****(Rev. 11771 ; Issued:12-30-22 ; Effective:01-01-23 ; Implementation:01-01-23)**

Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a nurse practitioner (NP) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below, and he or she is legally authorized to furnish NP services in the State where the services are performed. NPs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the NP benefit.

Payment for NP services is effective on the date of service, that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.

A. Qualifications for NPs

In order to furnish covered NP services, an NP must meet the conditions as follows:



- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or
- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation;
- National Board on Certification of Hospice and Palliative Nurses; and,
- Nurse Portfolio Credentialing Commission.

The NPs applying for a Medicare billing number for the first time on or after January 1, 2001, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

The NPs applying for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law;
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and
- Possess a master's degree in nursing or a doctor of nursing practice (DNP) doctoral degree.

B. Covered Services

Coverage is limited to the services an NP is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law).

1. General

The services of an NP may be covered under Part B if all of the following conditions are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets the definition of an NP (see subsection A);
- The NP is legally authorized to perform the services in the State in which they are performed;
- They are performed in collaboration with an MD/DO (see subsection D); and
- They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection C.2.)

2. Incident To

If covered NP services are furnished, services and supplies furnished incident to the services of the NP may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.



3. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B nurse practitioner covered services, the nurse practitioner may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the nurse practitioner's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

C. Application of Coverage Rules

1. Types of NP Services That May Be Covered



State law or regulation governing an NP's scope of practice in the State in which the services are performed applies. Consider developing a list of covered services based on the State scope of practice. Examples of the types of services that NPs may furnish include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of their State license, NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

See §60.2 for coverage of services performed by NPs incident to the services of physicians.

2. Services Otherwise Excluded From Coverage



The NP services may not be covered if they are otherwise excluded from coverage even though an NP may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within an NP's scope of practice under State law.

D. Collaboration



Collaboration is a process in which an NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

E. Direct Billing and Payment

Direct billing and payment for NP services may be made to the NP.

F. Assignment

Assignment is mandatory.

210 - Clinical Nurse Specialist (CNS) Services (Rev. 11771 ; Issued:12-30-22 ; Effective:01-01-23 ; Implementation:01-01-23)

Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a clinical nurse specialist (CNS) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below and he or she is legally authorized to furnish CNS services in the State where the services are performed. CNSs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the CNS benefit.

Payment for CNS services is effective on the date of service, that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.

A. Qualifications for CNSs

In order to furnish covered CNS services, a CNS must meet the conditions as follows:

1. Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;
2. Have a master's degree in a defined clinical area of nursing from an accredited educational institution or a doctor of nursing practice (DNP) doctoral degree; and

3. Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs.

The following organizations are recognized national certifying bodies for CNSs at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation;
- National Board on Certification of Hospice and Palliative Nurses; and,
- Nurse Portfolio Credentialing Commission.

B. Covered Services

Coverage is limited to the services a CNS is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law).

1. General

The services of a CNS may be covered under Part B if all of the following conditions are met:

- They are the types of services that are considered as physician's services if furnished by an MD/DO;
- They are furnished by a person who meets the CNS qualifications (see subsection A);
- The CNS is legally authorized to furnish the services in the State in which they are performed;
- They are furnished in collaboration with an MD/DO as required by State law (see subsection C); and
- They are not otherwise excluded from coverage because of one of the statutory exclusions. (See subsection C.)

2. Types of CNS Services that May be Covered

State law or regulations governing a CNS' scope of practice in the State in which the services are furnished applies. A/B MACs (B) must develop a list of covered services based on the State scope of practice.

Examples of the types of services that a CNS may furnish include services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. Also, if authorized under the scope of his or her State license, a CNS may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.

3. Incident To

If covered CNS services are furnished, services and supplies furnished incident to the services of the CNS may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.

4. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B Clinical Nurse Specialist (CNS) covered services, the CNS may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, medical; physician assistant; nurse practitioner; clinical nurse specialist; certified nurse-midwife; and certified registered nurse anesthetist students or other members of the medical team, including as applicable, notes documenting the CNS's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

C. Application of Coverage Rules

1. Types of CNS Services

Examples of the types of services that CNS may provide are services that traditionally have been reserved for physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition. State law or regulation governing a CNS' scope of practice for his or her service area applies.

2. Services Otherwise Excluded From Coverage

A CNS' services are not covered if they are otherwise excluded from coverage even though a CNS may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care and routine physical checkups and services that are not reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the function of a malformed body member. Therefore, these services are precluded from coverage even though they may be within a CNS' scope of practice under State law.

See §60.2 for coverage of services performed by a CNS incident to the services of physicians.

D. Collaboration

Collaboration is a process in which a CNS works with one or more physicians (MD/DO) to deliver health care services within the scope of the CNS' professional expertise with medical direction and appropriate supervision as required by the law of the State in which the services are furnished. In the absence of State law governing collaboration, collaboration is to be evidenced by the CNS documenting his or her scope of practice and indicating the relationships that the CNS has with physicians to deal with issues outside the CNS' scope of practice.

The collaborating physician does not need to be present with the CNS when the services are furnished or to make an independent evaluation of each patient who is seen by the CNS.

E. Direct Billing and Payment

A CNS may bill directly and receive direct payment for their services.

F. Assignment Requirement

Assignment is required for the service to be covered.

220 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance (Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

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

A. Definitions

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

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

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

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

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

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

A **DATE** may be in any form (written, stamped or electronic). The date may be added to the record in any manner and at any time, as long as the dates are accurate. If they are different, refer to both the date a service was performed and the date the entry to the record was made. For example, if a physician certifies a plan and fails to date it, staff may add "Received Date" in writing or with a stamp. The received date is valid for

certification/re-certification purposes. Also, if the physician faxes the referral, certification, or re-certification and forgets to date it, the date that prints out on the fax is valid. If services provided on one date are documented on another date, both dates should be documented.

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

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

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

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

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

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

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

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

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

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

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

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which

the services are furnished. Assistants are limited in the services they may furnish (see section 230.1 and 230.2) and may not supervise other therapy caregivers.

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

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

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

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

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

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

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

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

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

B. References

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

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

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

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

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

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

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

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

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

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

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

20 - Required and Optional CORF Services
 20.1 - Required Services
 20.2 - Optional CORF Services
 30 - Rules for Provision of Services
 30.1 - Rules for Payment of CORF Services
 40 - Specific CORF Services
 40.1 - Physicians' Services
 40.2 - Physical Therapy Services
 40.3 - Occupational Therapy Services
 40.4 - Speech Language Pathology Services

- Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL

- Part 1

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

- Part 2

150.2 - Osteogenic Stimulator

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

○ Part 3

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

○ Part 4

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

• Pub. 100-08 PROGRAM INTEGRITY MANUAL

○ Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.4.1.1 - Linking LCD and NCD ID Numbers to Edits

○ Chapter 13 - Local Coverage Determinations

13.5.1 - Reasonable and Necessary Provisions in LCDs

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

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

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

C. General

Therapy services are a covered benefit in §§1861(g), 1861(p), and 1861(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 - Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services

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



Reference: 42CFR424.24

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

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

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

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

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

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

- Services are or were required because the individual needed therapy services (see 42CFR424.24(c), §220.1.3);
- A plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP* (see 42CFR424.24(c), §220.1.2);
- Services are or were furnished while the individual is or was under the care of a physician* (see 42CFR424.24(c), §220.1.1);
 - In certifying an outpatient plan of care for therapy a physician/NPP is certifying that the above three conditions are met (42 CFR 424.24(c)). Certification is required for coverage and payment of a therapy claim.
- Claims submitted for outpatient (and CORF) PT, OT, and SLP services must contain the National Provider (NPI) of the certifying physician identified for a PT, OT, and SLP plan of care. This requirement is effective for claims with dates of service on or after October 1, 2012. (See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.3.)

- Claims submitted for outpatient (and CORF) PT, OT, and SLP services must contain the required functional reporting. (See 42CFR410.59, 60, and 62), Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6.) **NOTE:** The applicable regulatory provisions were removed through the CY 2019 PFS final rule, CMS-1693-F. Functional reporting requirements are no longer applicable for claims for dates of service on and after January 1, 2019. See the **NOTE** at the beginning of Section 220.4 for more information.

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

220.1.1 - Care of a Physician/Nonphysician Practitioner (NPP) (Rev. 179, Issued: 01-14-14, 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. 255, Issued: 01-25-19, Effective: 01-01-19, Implementation: 02-26-19)

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

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

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

The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the

plan, which is described below, is not the same as certifying the plan, which is described in §§220.1.1 and 220.1.3

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

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

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

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

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

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



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

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

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

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

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

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

There shall be different plans of care for each type of therapy discipline. When more than one discipline is treating a patient, each must establish a diagnosis, goals, etc. independently. However, the form of the plan and the number of plans incorporated into one document are not limited as long as the required information is present and related to

each discipline separately. For example, a physical therapist may not provide services under an occupational therapist plan of care. However, both may be treating the patient for the same condition at different times in the same day for goals consistent with their own scope of practice.

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

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

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

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

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

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



C. Changes to the Therapy Plan

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

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

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

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

physician's/NPP's signature required on the change, (long term goal changes may be accompanied by changes to procedures and modalities).



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

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

Reference: 42CFR424.24(c)

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

A. Method and Disposition of Certifications

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

The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility and/or practitioner. Acceptable documentation of certification may be, for example, a physician's progress note, a physician/NPP order, or a plan of care that is signed and dated by a physician/NPP, and indicates the physician/NPP is aware that therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan when there is evidence the plan was sent (e.g., to the office) or is available in the record (e.g., of the institution that employs the physician/NPP) for the physician/NPP to review. For example, if during the course of treatment under a certified plan of care a physician sends an order for continued treatment for 2 more weeks, contractors shall accept the order as certification of continued treatment for 2 weeks under the same plan of care. If the new certification is for less treatment than previously planned and certified, this new certification takes the place of any previous certification. At the end of the 2 weeks of treatment (which might extend more than 2 calendar weeks from the date the order/certification was signed) another certification would be required if further treatment was documented as medically necessary.

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

B. Initial Certification of Plan

The physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements noted above in §220.1 for the duration of the plan of care,

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

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



220.4 – Functional Reporting

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

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

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

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

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

Only one functional limitation shall be reported at a time. Consequently, the clinician must select the G-code set for the functional limitation that most closely relates to the primary functional limitation being treated or the one that is the primary reason for

treatment. When the beneficiary has more than one functional limitation, the clinician may need to make a determination as to which functional limitation is primary. In these cases, the clinician may choose the functional limitation that is:

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

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

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

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

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

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

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

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

Modifier	Impairment Limitation Restriction
CH	0 percent impaired, limited or restricted

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

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

- Uses the severity modifier that reflects the score from a functional assessment tool or other performance measurement instrument, as appropriate.
- Uses his/her clinical judgment to combine the results of multiple measurement tools used during the evaluative process to inform clinical decision making to determine a functional limitation percentage.
- Uses his/her clinical judgment in the assignment of the appropriate modifier.
- Uses the CH modifier to reflect a zero percent impairment when the therapy services being furnished are not intended to treat (or address) a functional limitation.

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

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

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

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

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

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

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

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

(Rev. 63, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01-29-07)

A. Group Therapy Services. Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

B. Therapy Students

1. General

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under “line of sight” supervision of the therapist; however, the presence of the student “in the room” does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present “in the room”.

EXAMPLES:

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

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.

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

2. Therapy Assistants as Clinical Instructors

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

3. Services Provided Under Part A and Part B

The payment methodologies for Part A and B therapy services rendered by a student are different. Under the MPFS (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or Resource Utilization Group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determines the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

230.1 - Practice of Physical Therapy

(Rev. 179, Issued: 01-14-14, 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. 179, Issued: 01-14-14, 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, A/B MACs (A), (B), and (HHH) exercise care in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and nonvocational purposes. For example, an assessment of sitting and standing tolerance might be nonvocational for a mother of young children or a retired individual living alone, but could also be a vocational test for a sales clerk. Training an amputee in the use of prosthesis for telephoning is necessary for everyday activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability. The techniques of adjustment cannot be considered exclusively vocational or nonvocational.

230.3 - Practice of Speech-Language Pathology

(Rev. 106, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)

A. General

Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See Pub. 100-03, chapter 1, §170.3) See section 230.4 of this chapter for benefit policies on speech-language pathologists in private practice (SLPP). See Pub. 100-08, Medicare Program Integrity Manual, chapter 10, section 12.4.14 for policy on enrollment in an SLPP.

B. Qualified Speech-Language Pathologist Defined

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

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

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

C. Services of Speech-Language Pathology Support Personnel

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

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

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

1. Evaluation Services

Speech-language pathology evaluation services are covered if they are reasonable and necessary and not excluded as routine screening by §1862(a)(7) of the Act. The speech-

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

2. Therapeutic Services

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

Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;

Neurological disease such as Parkinsonism or Multiple Sclerosis with dysarthria, dysphagia, inadequate respiratory volume/control, or voice disorder; or

Laryngeal carcinoma requiring laryngectomy resulting in aphonia.

3. Impairments of the Auditory System

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

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

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

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

4. Dysphagia

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

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

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



230.4 - Services Furnished by a Therapist in Private Practice (TPP) (Rev. 179, Issued: 01-14-14, 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. 179, Issued: 01-14-14, 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