DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Outpatient Rehabilitation Therapy Services
PAGE: 1 of 7	**REPLACES POLICY DATED:** 3/6/03, 3/1/04, 6/30/04, 11/1/05 (GOS.APS.002), 3/6/06, 11/15/06; 6/1/07; 5/1/08, 1/1/09, 2/1/11, 1/1/16, 2/1/17, 1/1/18, 1/1/19, 1/20/20
EFFECTIVE DATE: June 1, 2022	**REFERENCE NUMBER:** REGS.APS.002
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated hospitals providing and/or billing outpatient rehabilitation therapy services. Specifically, the following departments:

Shared Services Centers	Outpatient Rehabilitation Therapy Staff
Emergency Department	Same Day Surgery
Revenue Integrity	Administration

PURPOSE: To outline required billing guidelines for Medicare outpatient rehabilitation therapy services.

POLICY:

Outpatient rehabilitation therapy services must be billed in accordance with Centers for Medicare & Medicaid Services (CMS) requirements. These requirements must be met when providing rehabilitation services to patients in all outpatient settings, such as observation, same day surgery, or in the emergency department. All therapy services billed to Medicare must be skilled, medically necessary services appropriate to the beneficiary's plan of care. The conditions for coverage of outpatient Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services must be met in order to bill Medicare.

CONDITIONS FOR COVERAGE:

Outpatient physical therapy, occupational therapy, and/or speech language pathology services furnished to a Medicare beneficiary by a participating hospital are only covered when provided in accordance with the following requirements:

- Certification must be obtained at the time the plan of treatment is established (or as soon thereafter as possible). Recertification of the plan must be obtained at least every 90 calendar days or as specified in the plan of care (whichever is sooner).
- Certifications and recertifications must be signed by a physician or Advanced Practice Professional (Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant). (Refer to REGS.APS.001);
- The outpatient must be under the care of a physician or Advanced Practice Professional (APP);
- Services must be furnished under a written plan of care established by the physician/APP, physical therapist, occupational therapist, or speech language pathologist;
- Services must be furnished on an outpatient basis; and
- Services must be reasonable and necessary for the treatment of the patient's individual illness or injury.

PROCEDURE:

Each therapy director/manager should be familiar with the following sections of the CMS Manuals to ensure that all documentation requirements are being met:

- Medicare Claims Processing Manual, Chapter 5, Sections 10, 20, 30, 40, 100
- Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230

A. **Documentation**

1. The medical record must have documentation that is legible, relevant, and sufficient to support the patient's treatment and the codes submitted on the bill. The medical record documentation requirements (i.e., daily notes, progress notes) are outlined in the Medicare Claims Processing Manual, Chapter 5, and the Medicare Benefit Policy Manual, Chapter 15.

2. The plan of care must be established before treatment is begun. This plan may consist of specific orders by the physician or APP or a written plan of treatment after the therapist or speech-language pathologist concludes the evaluation. Treatment of the patient may begin before the plan is committed to writing only if the treatment is performed or supervised by the same qualified professional who established the plan and the plan is written and signed by the close of business on the next day by the same qualified professional.

3. The plan of care must detail the type, amount, frequency, and duration of the services to be provided. The plan must also indicate the diagnosis and anticipated goals. Any changes to the plan of care must be made in writing and signed by the physician, APP, therapist, or speech language pathologist.

4. The physician or APP may change a plan of treatment established by the therapist or speech language pathologist providing the services, but the therapist or speech language pathologist may not significantly alter a plan of treatment established by a physician or APP. A significant change in the plan of care by the therapist requires documented approval by the physician or APP. An example of significant change would be a change in long term goals. An insignificant alteration in the plan would be a decrease in the frequency or duration due to the patient's illness or a modification of short-term goals to adjust for improvements made toward the same long-term goals.

5. Documentation of the therapy provided to all patients must include the actual beginning and ending time of the treatment session. Although CMS allows for the documentation of actual start and stop times **or** total treatment times, the Company is taking a stronger stance and is requiring that actual start and stop times be documented for each treatment session. The Company has taken this stance so that facilities can determine if an overlap has occurred and prevent inappropriate billing (i.e., billing individual therapy when group therapy has been provided.)

If more than one modality or procedure is provided during a treatment session, facilities must also include total times and/or actual start and stop times for **each** modality or procedure provided.

Examples:
Patient A begins therapy at 8:00 a.m. and ends therapy at 8:30 a.m. Only one modality is provided. Documentation of the session start and stop time is required.

Patient B begins therapy at 9:00 a.m. and ends therapy at 9:30 a.m. During this time, the therapist provides 15 minutes of therapeutic exercise to the patient. The patient then rests for 5 minutes. The patient then receives 10 minutes of Ultrasound.

Documentation of start and stop times for the session is required. For the individual modality or procedure provided within that treatment session, the therapist must document either:

- 9:00 a.m. – 9:15 a.m. therapeutic exercises, 9:20 a.m. – 9:30 a.m. Ultrasound; total session time 9 a.m. – 9:30 a.m.; or
- 15 minutes therapeutic exercises, 5 minutes rest, 10 minutes Ultrasound, total session time 9:00 a.m. – 9:30 a.m.

6. Providers are to report the time actually spent in the delivery of the service requiring constant attendance (timed CPT codes). The time the patient spends not being treated (e.g., resting, waiting to use a piece of equipment, or for other treatment to begin) must not be billed.

7. The medical record must include documentation to indicate the total time therapy assistants (PTA/OTA) are involved in care to permit determination of whether therapy assistant modifiers are applicable.

B. **Billing**

1. Facilities may only bill Medicare for medically necessary skilled services.

2. Facilities must have a process to obtain certification and recertifications and other required documentation prior to billing.

3. When direct one-on-one patient contact is provided, individual therapy may be billed. The total minutes of skilled therapy services provided to the patient should be counted in order to determine how many units of service to bill the patient for the timed codes. Direct one-on-one minutes may occur continuously (15 minutes straight), or in notable episodes (for example, 10 minutes now, 5 minutes later).

4. CPT codes representing individual therapy are defined in 15-minute increments. The maximum number of timed therapy units that can be billed by a single therapist in a 60-minute period is 4 units.

5. For any timed CPT code, hospitals bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37, then 2 units should be billed. Time intervals for numbers of units are as follows:

1 unit	≥ 8 minutes through 22 minutes
2 units	≥ 23 minutes through 37 minutes
3 units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 97 minutes
7 units	≥ 98 minutes through 112 minutes
8 units	≥ 113 minutes through 127 minutes

   The pattern remains the same for treatment times in excess of 2 hours.

6. If more than one timed CPT code is billed to a patient during a single calendar day, the total number of units that can be billed is constrained by the total treatment time, per discipline, for that day. For example, if 24 minutes of neuromuscular reeducation (a timed CPT code) and 23 minutes of therapeutic exercises (a timed CPT code) were provided, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct billing is 2 units of neuromuscular reeducation and one unit of therapeutic exercise, assigning more units to the service that took the most time.

7. If any timed CPT code is performed for 7 minutes or less on the same day as another timed CPT code that was also performed for 7 minutes or less and the total treatment time is greater than 8 minutes, then bill for the service based on the total treatment time for the timed CPT codes. For example, if 6 minutes of ultrasound therapy (a timed CPT code) and 7 minutes of therapeutic exercise (a timed CPT code) were provided, then the total treatment time for the timed CPT codes is 13 minutes; so 1 unit of therapeutic exercise can be billed. Assign the unit to the service that required the most time.

8. When the therapist is providing timed modalities or procedures to two or more patients simultaneously, group therapy must be billed. For example, if the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, one unit of group therapy must be billed to each patient.

9. Group therapy and individual therapy may be billed to the same patient on the same day if the CPT definitions for both individual and group therapy are met. Group therapy and individual therapy must occur in different sessions, timeframes, or separate encounters that are distinct or independent from each other when billed on the same day. When both individual and group therapy services are provided on the same day in non-overlapping time periods it may be necessary to append an appropriate modifier to the individual treatment code when the codes are subject to a National Correct Coding (NCCI) edit.

10. An untimed procedure and a timed procedure performed on different patients during the same time period can be billed. For example, a therapist can perform Manual Therapy (a timed, one-on-one code) on Patient A while Patient B is receiving an unattended e-stim (an untimed code). Note: To be able to bill for the untimed code, the qualified personnel must perform the set-up of the modality.

11. Medicare does not reimburse for the services provided by aides, technicians, or therapy students regardless of the level of supervision. Therapy services may be billed when the aide, technician, or student is participating in the delivery of services and the qualified therapist is directing the service, making the skilled judgment and is responsible for the assessment and treatment of the patient. The therapist must be present and in the room for the entire session. The therapist must not be engaged in treating another patient or completing other tasks at the same time in order to bill individual therapy.

12. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same service, at the same time, to the same patient(s). If a physical and occupational therapist both provide therapy to one patient during the same 15-minute time period, only one therapist may bill. If a physical and occupational therapist both provide timed therapy to one patient during the same 30-minute period, one therapist may bill for the entire 30-minute time period (2 units of therapy), or each therapist may bill one unit of therapy.

13. Outpatient therapy codes for services provided under a therapy plan of care must include a modifier to indicate the discipline of the plan of care under which the service is delivered:
    - GP - Indicates services delivered under an outpatient **physical** therapy plan of care (under revenue code 42x)
    - GO - Indicates services delivered under an outpatient **occupational** therapy plan of care (under revenue code 43x)
    - GN - Indicates services delivered under an outpatient **speech-language** pathology plan of care (under revenue code 44x)

14. Outpatient therapy services furnished in whole or in part by a physical therapy assistant (PTA) or an occupational therapy assistant (OTA) may require a therapy assistant modifier to be reported beginning January 1, 2020. When the PTA or OTA furnishes more than 10% of the service, the appropriate modifier must be applied.
    - CQ – Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
    - CO – Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

C. **Education**

Education requirements will be reviewed and announced annually by Corporate Regulatory Compliance Support. Required education may also be announced throughout the year due to Federal regulatory changes. Only Company-designated programs may count towards this requirement.

All mandatory education requirements defined by Regulatory Compliance Support are included in the “Regs Education Grid” documents for the appropriate calendar year. These documents are located on Atlas Connect using the following link: http://connect.medcity.net/web/regs/regs-education

Facilities must be able to prove compliance with the education requirements when requested.

The Facility Ethics and Compliance Committee is responsible for the implementation and monitoring of this policy within the facility.

DEFINITIONS:

Certification/Recertification: The physician’s/APP’s approval of the plan of care.

Clinician: With respect to outpatient therapy services, a physician, nonphysician practitioner or a therapist (but not a therapy assistant, aide, or any other personnel) providing a service within the scope of practice and consistent with state and local law.

Group Therapy: The therapist, therapy assistant, or speech language pathologist provides care for two or more patients simultaneously. Group therapy involves constant attendance of the therapist but does not require direct one-on-one patient contact by the therapist. Patients receiving group therapy may be performing the same or different activities.

Individual Therapy: The therapist, therapy assistant, or speech language pathologist is in constant attendance with one patient and is providing direct, one-on-one attention to that patient. There may be other patients in the room or gym but the therapist, therapy assistant, or speech language pathologist cannot be providing any services to other patients including supervision or verbal cueing.

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Qualified Professional: A physical therapist, occupational therapist, speech language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also, may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapy assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law.

Skilled Services: Services that are of such a level of complexity and sophistication or situations in which the condition of the patient is such that the services required can be safely and effectively performed only by or under the supervision of a qualified therapist or speech pathologist are considered skilled services. Services that do not require the performance or supervision of a therapist or speech language pathologist are not considered reasonable or necessary therapy services even if they are performed or supervised by a therapist or speech language pathologist. Supervising a patient independently performing a therapeutic exercise program is not considered a skilled service. For the service to be considered skilled in the group therapy setting, the supervision of the patients must be sufficiently close so that the therapist can take a step or two and intervene in the care of any of the patients being treated.

Timed Codes: Individual therapy codes that require direct, one-on-one contact and have time requirements in the code definition (e.g., "each 15 minutes"). In the American Medical Association (AMA) CPT codebook, these codes represent the constant attendance modalities and all therapeutic procedures in the Physical Medicine and Rehabilitation section.

Untimed Codes: Codes that do not have time requirements in the code definition. In this policy this term is used for codes that do not have time requirements in the code definition and do not require direct, one-on-one contact by the provider. In the AMA CPT codebook, these codes are those listed as supervised modalities in the Physical Medicine and Rehabilitation section.

Visits or Treatment Sessions: Begin at the time the patient enters the treatment area 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 visit/treatment sessions are billable (e.g., rest periods).

REFERENCES:

1. CMS 11 Part B Billing Scenarios for PTs and OTs
2. CY CPT code book, American Medical Association
3. 42 CFR 484.4
4. Certification and Recertification for Post-Acute Services Policy, REGS.APS.001
5. Medicare Claims Processing Manual, Chapter 5, Sections 10, 20, 30, 40, 100
6. Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230
7. Outpatient Rehabilitation Therapy Resource Manual
8. CMS Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements