FACT SHEET

Plan of Care

All physical and occupational therapy (as well as speech language pathology services) must be provided under a plan of care. There are requirements for both the plan of care and claim submission for these services. To designate the discipline associated with the plan of care, submit these services with the appropriate HCPCS modifier (note: one of these modifiers is REQUIRED with each therapy service submitted):

- GN: Services delivered under an outpatient **speech language pathology** plan of care
- GO: Services delivered under an outpatient **occupational therapy** plan of care
- GP: Services delivered under an outpatient **physical therapy** plan of care

Establishing the Plan - Services Must:

- Relate directly and specifically to a written treatment plan
- Be established before treatment is begun
- Be documented with the signature and professional designation (e.g., MD, OTR/L) of person who established the plan and the date the plan was established

Contents of Plan

At a minimum, the following information is required by regulation 42CFR424.24, 410.61, and 410.105(c):

- Diagnoses
- Long term treatment goals (should be measurable and pertain to identified functional impairments)
- Type (may be PT, OT, or SLP where appropriate the type may be a description of a specific treatment or intervention)
- Amount (refers to number of times in a day the type of treatment will be provided)
- Duration (number of weeks, or treatment sessions for THIS plan of care)
- Frequency (number of times in a week the type of treatment is provided)

Significant Changes to the Therapy Plan

- Changes are made in writing in the patient's record and signed by the professionals responsible for the patient's care
- Therapist may NOT significantly alter a plan established or certified by a physician/ NPP without that ordering physician/NPP's documented written or verbal approval
- Certification of the significantly modified plan shall be obtained with 30 days of the initial therapy treatment under the revised plan

The plan shall be consistent with the related evaluation, strive to provide treatment in the most efficient and effective manner, and balance the best achievable outcome with appropriate resources.

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 (LCDs), which are housed in the CMS Medicare Coverage Database at http://www.cms.gov/mcd.

Outpatient Physical and Occupational Therapy Service are currently covered under LCD L34049. An accompanying article (A57067) discussing billing and coding for outpatient therapy services is linked in the Associated Documents Section of the LCD (https://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=238&ContrVer=2&CntrctrSelected=238*2&bc=AAACAAAAAAAA&DocType=2#aFinal).

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services submitted to Medicare must meet Medical Necessity guidelines. The definition of "medically necessary" for Medicare purposes can be found in Section 1862(a)(1)(A) of the Social Security Act – Medical Necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

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Certification and Recertification

Method and Disposition

- Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.
- The physician/NPP ordering the therapy should be the provider that signs the plan of care. It is not appropriate for the physician/NPP to certify the plan of care if the patient did not need treatment or the patient is not under that provider's care.
- The certification must include the date the ordering physician/NPP signs the document.
- Certification MUST relate to treatment during the interval on the claim.
- There is no required, specific format for certifications or recertifications.

Initial Certification

- Physician's/NPP's certification of the plan (with or without an order) satisfies all the certification requirements for the duration of the plan or 90 calendar days from the date of the initial treatment, whichever is less.
- Obtain certification as soon as possible after the plan of care is established or within 30 days of the initial therapy treatment.
- If the order to certify is verbal, it MUST be followed within 14 days by a signature to be considered timely.

Recertification

- Payment and coverage conditions require that the plan must be reviewed as often as necessary but at least whenever it is certified or recertified.
- Recertifications that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initiation of treatment under that plan.

Delayed Certification

- Should include any evidence the provider considers necessary to justify the delay
- Long delayed certification (over 6 months), the provider may choose to submit with the delayed certification some other document indicating the need for care and that the patient was under the care of a physician at the time of the treatment (e.g., progress notes, order, telephone contact)
- Reference: §1835(a) of the Act 42CFR424.11(d)(3) http://www.ssa.gov/OP_Home/ssact/title18/1835.htm

Denial for payment that is based on absence of certification is a technical denial, which means a statutory requirement has not been met. Certification is a statutory requirement in SSA 1835(s)(2).

Progress notes

- The progress note serves as documentation of ongoing medical necessity of therapy.
- Progress notes are required on every tenth visit or at the time of significant change in clinical condition. Certifying physicians do not need to sign progress notes.
- Progress notes are required to show measurable indicators of loss of function and the impact on patient's life. Documentation should also show functional

Reasonable and Necessary

To be considered reasonable and necessary, each of the following conditions must be met (this is a representative list of required conditions and does not fully describe reasonable and necessary services):

The service is considered, under accepted standards of medical practice, to be a specific and effective treatment for the patient's condition.

The service is of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist or under the supervision of a therapist.

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improvement, decline or any small changes that support ongoing medical necessity of therapy.
- Ongoing therapy beyond the recommended number of visits found in the corresponding LCD should be supported in the progress notes.

Additional Information

- **Therapy caps and Advance Beneficiary Notices of Noncoverage (ABNs):** Claims for therapy services denied because they are not considered reasonable and necessary under §1862(a)(1)(A) of the Act, and those denied as a result of application of the therapy caps under §1833(g)(1) or (g)(3) of the Social Security Act, are subject to consideration under the waiver of liability provision in §1879 of the Act. This means it is appropriate to, and you are encouraged to, ask patients for whom additional provided services are likely to exceed the therapy cap, to sign an ABN.
  - If you obtained a signed and valid ABN and CGS (or another authorized contractor) requests additional supporting documentation, include a copy of the ABN with your other documentation.
  - The standard ABN form and additional guidance regarding ABN usage is available on the CMS Beneficiary Notices Initiative Web page: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html
- **Ensure medical records are signed:** Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed.
  - Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in CMS MLN Matters article MM8219: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf
  - You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in CMS MLN Matters article MM6698: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf
  - A sample attestation statement is available on the CGS website: http://www.cgsmedicare.com/partb/cert/attestation_form.pdf
  - Guidelines regarding signature requirements are located in the CMS Medicare Benefit Policy Manual (Pub. 100-08), chapter 3, section 3.3.2.4: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

References

- CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 15, section 220 Coverage of Outpatient Rehabilitation Therapy Services: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- CMS Medicare Learning Network Outpatient Rehabilitation Therapy Services Fact Sheet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OutptRehabTherapy-Booklet-MLN905365.pdf
- CMS Therapy Services Web page: http://www.cms.gov/Medicare/Billing/TherapyServices/index.html

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