



MEDICARE OUTPATIENT PHYSICAL THERAPY SELF HELP PACKET

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INTRODUCTION

Dear Medicare Patient:

The Center for Medicare Advocacy, in conjunction with the State of Connecticut Department of Social Services has produced this packet of materials to help you understand Medicare coverage and to file an appeal if it is necessary.

Medicare is the national health insurance program to which individuals are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right to appeal an unfair denial; we urge you to do so.

The materials enclosed include a Request for Redetermination form which has accompanying instructions for completing and filing. In order to appeal your Medicare denial, you must file the Request for Redetermination with the Medicare contractor. You will receive a Redetermination decision usually within one to three months after submitting the request.

Please do not hesitate to contact The Center for Medicare Advocacy at (800)262-4414 or (860)456-7790 if you have any questions.



HOW TO USE THIS PACKET

We've organized this packet so that it provides you with the information and forms necessary to enable you to evaluate your case and file a "Request for Redetermination," the first level of administrative appeal. We suggest you take the following steps:

1. Read the "Brief Summary." This summary will give you the background necessary to understand your case.
2. If your case has merit (that is, the coverage denial you have received is erroneous), you should complete the "Request for Redetermination" form, following the Instructions.
3. Send a copy of your "Request for Redetermination" to your Medicare contractor. Keep a copy of the form for your own records.
4. If you have questions when you receive the "Redetermination" decision, feel free to telephone the Center for Medicare Advocacy. The toll free number in Connecticut is 800-262-4414.



A BRIEF SUMMARY OF MEDICARE COVERGE FOR OUTPATIENT PHYSICAL THERAPY AND THE IMPROVEMENT MYTH

Medicare is the national health insurance program to which all Social Security recipients who are either at least 65 years old or are permanently disabled are entitled. In addition, individuals receiving Railroad Retirement benefits and individuals with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS) are eligible to receive Medicare benefits. Medicare was established in 1965 by Title 18 of the Social Security Act. 42 USC §1395 *et seq.*

Private Medicare plans are known as "Medicare Advantage" (MA) plans. Although the Medicare Advantage system is different from the original Medicare program, *Medicare Advantage plan benefits are required to be identical to, or more generous than, those in the original program.*

THE MEDICARE “IMPROVEMENT MYTH”

There is a long standing myth that Medicare coverage is not available for beneficiaries who have an underlying condition from which they will not improve. This is not true. In fact, the notion of "improvement" is only mentioned once in the Medicare Act – and it is not about coverage for physical therapy.

As an overarching principle, the Medicare Act states that no payment will be made except for items and services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member." 42 USC §1395y(a)(1)(A). While it is not clear what a "malformed body member" is, clearly this language does not limit Medicare coverage only to services, diagnoses or treatments that will improve illness or injury. Yet, in practice, beneficiaries are often denied coverage on the grounds that they are not likely to improve, or are "stable," or "chronic," or require long-term care, or "maintenance services only." *These are not legitimate reasons for Medicare denials.*

Medicare policy regarding coverage of outpatient physical therapy is lengthy and at times seems inconsistent. However, the policy states that outpatient therapy services may be necessary to establish a safe and effective maintenance program required in connection with a specific disease state. In addition, the policy goes on to state that in the case of a progressive degenerative disease [such as multiple sclerosis, Parkinson’s disease, or amyotrophic lateral sclerosis (ALS)] therapy services may be necessary to determine the need for assistive equipment and/or establish a program to maximize function. Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, §220.2D.

As examples, the goals of a Medicare covered maintenance program could be to maintain function or to prevent further decline in function. The specialized skill, knowledge and judgment of a therapist would be required to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan. Moreover, when the patient's safety is at risk and the services that are required to maintain function involve the use of complex and sophisticated therapy techniques, the therapist's services are covered, *even if the skills of a therapist are not ordinarily needed to carry out the activities.* Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, §220.2D.

A beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury. Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, §220.2B.

The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve or maintain the patient's condition. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist. Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, §220.2C.

MEDICARE COVERAGE FOR OUTPATIENT PHYSICAL THERAPY

Physical therapy services can be covered by Medicare Part B for people residing in the community, and for those with continuing hospital or nursing home stays that are not otherwise covered by Medicare, if they meet the following criteria:

1. The therapy services are furnished while the beneficiary is under the care of a physician. 42 CFR §410.60(a)(1).
2. The services are furnished under a written plan of care that is established by a physician or a physical therapist before treatment is begun. 42 CFR §§410.60 (a)(2) and 410.61(b). The written plan of care must prescribe the type, amount, frequency and duration of the therapy services, and must indicate the diagnosis and anticipated goals. 42 CFR §410.61(c)
3. The services must be performed by, or under the direct supervision of, a physical therapist. All services not performed personally by the therapist must be performed by employees of the practice, supervised by the therapist, and included in the fee for the therapist's services. 42 CFR §410.60(c)(2).
4. The services must be medically reasonable and necessary, which means that the services provided are considered specific and effective treatment for the patient's condition under accepted standards of medical practice. Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, §220.2B.
5. The services must be sufficiently complex, or 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 physical therapist. (Services that do not require the performance or

supervision of a skilled physical therapist are not coverable, even if they are in fact performed or supervised by a skilled physical therapist). Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, §220.2C.

IMPORTANT ADVOCACY TIPS

1. Each person should get an individualized assessment regarding Medicare coverage based on his/her unique medical condition and need for care.
2. Unfortunately, Medicare coverage is often denied to individuals who qualify under the law. In particular, beneficiaries are often denied coverage because they have certain chronic conditions such as multiple sclerosis, traumatic brain injury, Alzheimer's disease, Parkinson's disease, or because they need therapy "only" to maintain their condition. These are **not** legitimate reasons for Medicare denials.
3. A beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist.
4. Medicare recognizes that skilled services can be required to maintain an individual's condition or functioning, or to slow or prevent deterioration, including physical therapy to maintain the individual's condition or function.
5. Services that can ordinarily be performed by non-skilled personnel should be considered skilled services if, because of medical complications, a skilled physical therapist is required to perform or supervise the services.
6. The doctor is the patient's most important ally. Ask the doctor to help demonstrate that the standards described above are met. In particular, *ask the individual's doctor to state in writing why the skilled care and other services are required. If possible, also get a supportive statement from the physical therapist.*

The question to ask is does the patient meet the qualifying criteria listed above and need skilled therapy – not does the patient have a particular disease or will s/he recover.

Submit a Claim: If a Medicare beneficiary is told that Medicare coverage for therapy is not available and the patient seems to satisfy the criteria described above, ask the health care provider to submit a claim to Medicare. The submission of a claim to Medicare is the only way to obtain a formal Medicare coverage determination and to access the Medicare appeals process if coverage is denied. The provider must submit a Medicare claim at the patient's or representative's request.

Annual Medicare Payment Limit: There is an annual Medicare payment cap on outpatient physical, speech, and occupational therapy services. **For 2010 the annual cap is \$1,860 for physical and speech therapy combined.**

- The annual cap in 2010 for occupational therapy is \$1,860.
- In past years, Congress established an "Exceptions" process, which allowed Medicare coverage for specific diagnoses and procedures even after a beneficiary met their therapy cap for the year. However, Congress has not re-authorized this exception process for services received in calendar year 2010 or beyond.
- The outpatient therapy caps do not apply if the therapy services are received in an outpatient hospital facility or in emergency rooms.

CONCLUSION

Medicare coverage for physical therapy can be a long-term benefit if the individual meets the qualifying criteria, has not exceeded the annual payment cap, or is receiving services in a facility that is not subject to the cap. Unfortunately, however, coverage is often erroneously denied for individuals who have chronic conditions, for people who are not improving, or who need therapy to maintain their level of function.

Medicare can be available for therapy that is needed to maintain the person's condition or to prevent further deterioration. It is not always necessary for the individual's underlying condition to improve to qualify for Medicare coverage! The Medicare program has an appeal system to contest such denials. Beneficiaries and their advocates should use this system to appeal Medicare determinations that unfairly deny or limit coverage.

For more information about Medicare coverage, appeals, and related topics visit the Center for Medicare Advocacy's web site at www.medicareadvocacy.org .



Medicare Overview

Generally, coverage is available (except for hospice care) only when services are medically reasonable and necessary for treatment or diagnosis of illness or injury.

PART A

Coverage:

- Inpatient Hospital Services
- Inpatient Hospital Rehabilitation Services
- Inpatient Skilled Nursing Facility Services
- Home Health Services
- Hospice Services

PART B

Coverage:

- Physicians' Services
- Some Outpatient Services & Therapy
- Prosthetic Devices
- Ambulance Services
- Preventive Screenings such as:
prostate cancer, bone mass, glaucoma
- Some Nutrition Therapy Services
- Flu and Pneumonia Vaccines
- Some Therapeutic Shoes

Appeals Process

1. Redetermination (by Quality Improvement Organization [QIO] or Medicare Contractor)
2. Reconsideration (by Qualified Independent Contractors (QIC))
3. Administrative Law Judge Hearing (U.S. Dept. of Health & Human Services) [If at least \$130 in controversy]*[\$200 for Hospital Case]
4. Medicare Appeals Council (MAC) (U.S. Dept. of Health and Human Services) [If at least \$130 in controversy]* [\$200 for Hospital Case]
5. Judicial Review (U.S. Dept. of Health and Human Services) [If at least \$1,260 in controversy]* [\$200 for Hospital Case]

* The amount in controversy is increased by the percentage increase in the medical care component price index.



MEDICARE PREMIUMS AND DEDUCTIBLES FOR 2010

Hospital Deductible: \$1,100.00 / Benefit period

Hospital Coinsurance:

- Days 0-60: \$0
- Days 61-90: \$275 / Day
- Days 91-150: \$550 / Day

Skilled Nursing Facility Coinsurance:

- Days 0-20: \$0
- Days 21-100: \$137.50 / Day

Part A Premium (For voluntary enrollees only)

- With 30-39 quarters of Social Security coverage: \$254 / Month
- With 29 or fewer quarters of Social Security coverage: \$461 / Month

Part B

- Deductible: \$155 / Year
- Standard Premium: \$110.50 / Month*

PART B INCOME-RELATED PREMIUM

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0	\$110.50*
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$44.20	\$154.70
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$110.50	\$221.00
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$176.80	\$287.30
Greater than \$214,000	Greater than \$428,000	\$243.10	\$353.60

PART B PREMIUM (cont.)

In addition, the monthly Part B premium rates to be paid by beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at some time during the taxable year are:

Beneficiaries who are married but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$110.50*
Greater than \$85,000 and less than or equal to \$129,000	\$176.80	\$287.30
Greater than \$129,000	\$243.10	\$353.60

*The majority of beneficiaries will not see an increase in their Part B monthly premium from the 2009 amount (\$96.40) thanks to the "hold harmless" provision of the Social Security Act (42 U.S.C. §1395r(f)). See the discussion of the hold harmless provision that is included in the following weekly alert: http://www.medicareadvocacy.org/PartB_09_08.27.PremiumsandCOLA.htm.

STANDARD PART D COST-SHARING FOR 2010

Deductible: \$310.00

Initial Coverage Limit: \$2,830.00

Out-of-pocket Threshold: \$4,550.00

Total Covered Part D Drugs to Get to Catastrophic Limit: \$6,440

Catastrophic cost-sharing: Generic/ Preferred Drug: \$2.50

Other Drugs: \$6.30



MEDICARE PART B APPEALS

(Includes claims for physician's services, out-patient physical therapy, x-ray and other diagnostic laboratory testing, durable medical equipment & ambulance services)

Stage of Appeal:	Redetermination Request	Reconsideration Request	Administrative Law Judge (ALJ) Hearing Request	Request for Medicare Appeals Council	Request For Judicial Review
Time Deadline for Filing Appeal:	Within 120 Days of receipt of "Initial Determination"	Within 180 Days of receipt of "Redetermination"	Within 60 Days of receipt of "Reconsideration Determination"	Within 60 Days of receipt of ALJ "Hearing Decision"	Within 60 Days of receipt of "MAC Decision"
Amount of Claim:	No Minimum	No Minimum	\$130 Minimum*	\$130 Minimum *	\$1,260 Minimum*
File Appeal Request With:	Medicare Contractor (Carrier)	Qualified Independent Contractor (QIC)	Qualified Independent Contractor (QIC)	U.S. Dept. of Health and Human Services	United States District Court
Appeal Reviewed & Decided By:	Medicare Contractor	Qualified Independent Contractor (QIC)	Administrative Law Judge from US Dept. of Health and Human Services	U.S. Dept. of Health and Human Services Medicare Council	United States District Court

* For 2010, amount in controversy is increased annually by the percentage increase in the medical care component price index.



INSTRUCTIONS FOR COMPLETING REDETERMINATION REQUEST FORM

Although most sections of the form are self-explanatory, a few sections may not be so clear. Below are instructions for completing those sections as well as instructions for submitting your Request for Redetermination. Remember to refer to the included Glossary of Terms if need be.

- #2. Medicare Number- This number can be found in the upper right section of the “Medicare Summary Notice.” You can also use the Social Security number under which you receive benefits. Your Medicare Number can also be found on your Medicare card.
- #5. My reasons are: - Fill in the following: “The services provided are coverable under the Medicare Act.” If you missed the 120 day appeal deadline, you will need to establish “good cause” for late filing of your Request Redetermination. Here are some acceptable “good cause” reasons.
- #6. Date of the initial determination notice-The date can be found on the “Medicare Summary Notice” in a box in the upper Right hand corner.

If you received your initial determination notice more than 120 days ago, include your reason for late filing from the options below:

- a. During the time in question, the patient suffered from (list illnesses), and thus was unable to attend to matters of personal business. Waiver is sought pursuant to 42 CFR §405.942(b)(i).
- b. During the time in question, the patient had a death or serious illness in his/her immediate family. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iii).
- c. Important records were destroyed or damaged by fire or other accidental cause. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iii).
- d. The Medicare contractor did not give the patient correct or complete information about when or how to request a Redetermination. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iv).
- e. The patient did not receive the initial determination. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(v).

- f. The patient sent the request to a government agency in good faith within the time limit but the request did not reach the appropriate contractor until after the time period had passed. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(vi.)

If you are representing the beneficiary, have him/her sign the Appointment of Representative form included in this packet and attach a copy with the Request for Redetermination.

When completed, keep a copy for your records and deliver/mail* the original to the Medicare contractor. Attach a copy of the Medicare denial notice being appealed, and if appropriate, copies of your Appointment Representative form.

REMEMBER: KEEP THE ORIGINAL OR A COPY OF ALL PAPERS YOU SUBMIT.

*Name and Address of the Medicare Contractor can be found on the “Medicare Summary Notice”.

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:

6. Date of the initial determination notice _____
(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

7. Additional Information Medicare Should Consider: _____

8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. I have evidence to submit. (Attach such evidence to this form.)
 I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER
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SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY	DATE	
STREET ADDRESS	PHONE NUMBER (AREA CODE)	
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE	DATE	
STREET ADDRESS	PHONE NUMBER (AREA CODE)	
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
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SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE
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CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



GLOSSARY OF TERMS

BENEFICIARY

An individual enrolled in the Medicare program.

CLAIMANT

An individual requesting reimbursement from Medicare for expenses incurred for medical care (or the individual requesting payment on behalf of a Medicare enrollee).

CO-INSURANCE

The amount a beneficiary must pay as his or her share of the cost of a given service. For example, a beneficiary must pay part of the cost of days 21 through 100 in a skilled nursing facility. There is also a co-insurance (20% of the reasonable charge) which must be paid for Part A or B services.

CMS (Centers for Medicare and Medicaid Services)

The federal agency which administers the Medicare program: part of the United States Department of Health and Human Services.

DEDUCTIBLE

The amount which a beneficiary must pay before Medicare (or other insurance program) will begin to cover the bill. Each calendar year a deductible must be paid before Medicare will cover hospital care under Part A, or physician visits and other services under Medicare Part B.

HEALTH INSURANCE CLAIM NUMBER

The Social Security number under which you receive benefits. This number is the number on your health insurance (Medicare) card.

INPATIENT

An individual admitted to a hospital, skilled nursing facility, or other health care institution for treatment

MEDICARE CLAIM DETERMINATION

The written notice of denial of Medicare coverage issued by the intermediary.

MEDICARE CONTRACTOR

An agent of the federal government, often an insurance company, which makes Part A Medicare claim determinations for skilled nursing facility and home health coverage, and issues payments to providers.

MEDIGAP

Private insurance which covers the "gaps" in Medicare (such as deductibles and co-insurance amounts). Significantly, these policies generally do not pay when Medicare refuses coverage.

SKILLED CARE

Care which requires the skill of technical or professional personnel in order to ensure its safety and effectiveness, and is furnished directly by, or under the supervision of, such personnel. (Nurses and physical or occupational therapists are examples of professional personnel.)

SKILLED NURSING FACILITY (SNF)

A skilled nursing facility, or "SNF," is a nursing home which delivers a relatively substantial degree of skilled nursing and rehabilitative care, and personal care. In order to receive Medicare coverage for nursing home care, a patient must receive daily skilled care in a Medicare-certified skilled nursing facility.

SPELL OF ILLNESS (BENEFIT PERIOD)

The name of the benefit period for Medicare Part A. The "spell of illness" begins on the first day a patient receives Medicare-covered inpatient hospital care and ends when the patient has spent 60 consecutive days outside the institution, or remains in the institution but does not receive Medicare-coverable care for 60 consecutive days.

REGULATIONS — MEDICARE PART B

VOL. 42, CODE OF FEDERAL REGULATIONS

§§410.59 — 410.62

RE: OUTPATIENT THERAPIES

§410.57

this section for a woman of childbearing age who has had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding 3 years. The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or a qualified practitioner, as specified in paragraph (a) of this section, to be of childbearing age, based on her medical history or other findings.

(4) *Limitation applicable to women at high risk and those of childbearing age.* Payment is not made for a screening pelvic examination for women considered to be at high risk (under any of the criteria described in paragraph (b)(2) of this section), or who qualify for coverage under the childbearing provision (under the criteria described in paragraph (b)(3) of this section) more frequently than once every 11 months after the month that the last screening pelvic examination covered by Medicare was performed.

[62 FR 59101, Oct. 31, 1997; 63 FR 4596, Jan. 30, 1998, as amended at 66 FR 55329, Nov. 1, 2001]

§410.57 Pneumococcal vaccine and flu vaccine.

(a) Medicare Part B pays for pneumococcal vaccine and its administration when reasonable and necessary for the prevention of disease, if the vaccine is ordered by a doctor of medicine or osteopathy.

(b) Medicare Part B pays for the influenza virus vaccine and its administration.

[63 FR 35066, June 26, 1998]

§410.58 Additional services to HMO and CMP enrollees.

Services not usually covered under Medicare Part B may be covered as medical and other health services if they are furnished to an enrollee of an HMO or a CMP and the following conditions are met:

(a) The services are—

(1) Furnished by a physician assistant or nurse practitioner as defined in §491.2 of this chapter, or are incident to services furnished by such a practitioner; or

42 CFR Ch. IV (10-1-09 Edition)

(2) Furnished by a clinical psychologist as defined in §417.416 of this chapter to an enrollee of an HMO or CMP that participates in Medicare under a risk-sharing contract, or are incident to those services.

(b) The services are services that would be covered under Medicare Part B if they were furnished by a physician or as incident to a physician's professional services.

§410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient occupational therapy services only if they are furnished by an individual meeting the qualifications in part 484 of this chapter for an occupational therapist or an appropriately supervised occupational therapy assistant but only under the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of §410.61.

(3) They are furnished—

(i) By a provider as defined in §489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By, or under the direct supervision of, an occupational therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform occupational therapy services within the scope of State law. When an occupational therapy service is provided incident to the service of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service

must meet the standards and conditions that apply to occupational therapy and occupational therapists, except that a license to practice occupational therapy in the State is not required.

(b) *Conditions for coverage of outpatient therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* Medicare Part B pays for outpatient occupational therapy services furnished to an inpatient of a hospital, CAH, or SNF who requires them but who has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by occupational therapists in private practice—(1) Basic qualifications.* In order to qualify under Medicare as a supplier of outpatient occupational therapy services, each individual occupational therapist in private practice must meet the following requirements:

(i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of occupational therapy by the State in which he or she practices, and practice only within the scope of his or her license, certification, or registration.

(ii) Engage in the private practice of occupational therapy on a regular basis as an individual, in one of the following practice types:

(A) An unincorporated solo practice.

(B) A partnership or unincorporated group practice.

(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated occupational therapy practice.

(D) An employee of a physician group.

(E) An employee of a group that is not a professional corporation.

(iii) Bill Medicare only for services furnished in his or her private practice office space, or in the patient's home. A therapist's private practice office space refers to 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 practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented

by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, an CAH, or a SNF.

(iv) Treat individuals who are patients of the practice and for whom the practice collects fees for the services furnished.

(2) *Supervision of occupational therapy services.* Occupational therapy services are performed by, or under the direct supervision of, an occupational therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

(d) *Excluded services.* No service is included as an outpatient occupational therapy service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

(e) *Annual limitation on incurred expenses.* (1) Amount of limitation. (i) In 1999, 2000, and 2001, no more than \$1,500 of allowable charges incurred in a calendar year for outpatient occupational therapy services are recognized incurred expenses.

(ii) In 2002 and thereafter, the limitation is determined by increasing the limitation in effect in the previous calendar year by the increase in the Medicare Economic Index for the current year.

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

(2) For purposes of applying the limitation, outpatient occupational therapy includes:

(i) Except as provided in paragraph (e)(3) of this section, outpatient occupational therapy services furnished under this section;

(ii) Outpatient occupational therapy services furnished by a comprehensive outpatient rehabilitation facility;

(iii) Outpatient occupational therapy services furnished by a physician or incident to a physician's service;

(iv) Outpatient occupational therapy services furnished by a nurse practitioner, clinical nurse specialist, or physician assistant or incident to their services.

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(3) For purposes of applying the limitation, outpatient occupational therapy services excludes services furnished by a hospital directly or under arrangements.

[63 FR 58906, Nov. 2, 1998, as amended at 67 FR 80040, Dec. 31, 2002; 69 FR 66421, Nov. 15, 2004; 72 FR 66399, Nov. 27, 2007]

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in part 484 of this chapter for a physical therapist or an appropriately supervised physical therapist assistant but only under the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By, or under the direct supervision of a physical therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform physical therapy services under State law. When a physical therapy service is provided incident to the service of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to physical therapy and physical therapists, except that a license to practice physical therapy in the State is not required.

(b) *Condition for coverage of outpatient physical therapy services furnished to cer-*

tain inpatients of a hospital or a CAH or SNF. Medicare Part B pays for outpatient physical therapy services furnished to an inpatient of a hospital, CAH, or SNF who requires them but who has exhausted or is otherwise +ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by physical therapists in private practice—*(1) *Basic qualifications.* In order to qualify under Medicare as a supplier of outpatient physical therapy services, each individual physical therapist in private practice must meet the following requirements:

(i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of physical therapy by the State in which he or she practices, and practice only within the scope of his or her license, certification, or registration.

(ii) Engage in the private practice of physical therapy on a regular basis as an individual, in one of the following practice types:

(A) An unincorporated solo practice.

(B) An unincorporated partnership or unincorporated group practice.

(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice.

(D) An employee of a physician group.

(E) An employee of a group that is not a professional corporation.

(iii) Bill Medicare only for services furnished in his or her private practice office space, or in the patient's home. A therapist's private practice office space refers to 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 practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

(iv) Treat individuals who are patients of the practice and for whom the

practice collects fees for the services furnished.

(2) *Supervision of physical therapy services.* Physical therapy services are performed by, or under the direct supervision of, a physical therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

(d) *Excluded services.* No service is included as an outpatient physical therapy service if it would not be included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

(e) *Annual limitation on incurred expenses.* (1) Amount of limitation. (i) In 1999, 2000, and 2001, no more than \$1,500 of allowable charges incurred in a calendar year for outpatient physical therapy services are recognized incurred expenses.

(ii) In 2002 and thereafter, the limitation shall be determined by increasing the limitation in effect in the previous calendar year by the increase in the Medicare Economic Index for the current year.

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

(2) For purposes of applying the limitation, outpatient physical therapy includes:

(i) Except as provided in paragraph (e)(3) of this section, outpatient physical therapy services furnished under this section;

(ii) Except as provided in paragraph (e)(3) of this section outpatient speech-language pathology services furnished under §410.62;

(iii) Outpatient physical therapy and speech-language pathology services furnished by a comprehensive outpatient rehabilitation facility;

(iv) Outpatient physical therapy and speech-language pathology services furnished by a physician or incident to a physician's service;

(v) Outpatient physical therapy and speech-language pathology services furnished by a nurse practitioner, clinical nurse specialist, or physician assistant or incident to their services.

(3) For purposes of applying the limitation, outpatient physical therapy ex-

cludes services furnished by a hospital or CAH directly or under arrangements.

[63 FR 58906, Nov. 2, 1998, as amended at 67 FR 80041, Dec. 31, 2002; 69 FR 66422, Nov. 15, 2004; 72 FR 66399, Nov. 27, 2007]

§410.61 Plan of treatment requirements for outpatient rehabilitation services.

(a) *Basic requirement.* Outpatient rehabilitation services (including services furnished by a qualified physical or occupational therapist in private practice), must be furnished under a written plan of treatment that meets the requirements of paragraphs (b) through (e) of this section.

(b) *Establishment of the plan.* The plan is established before treatment is begun by one of the following:

(1) A physician.

(2) A physical therapist who furnishes the physical therapy services.

(3) A speech-language pathologist who furnishes the speech-language pathology services.

(4) An occupational therapist who furnishes the occupational therapy services.

(5) A nurse practitioner, a clinical nurse specialist, or a physician assistant.

(c) *Content of the plan.* The plan prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals.

(d) *Changes in the plan.* Any changes in the plan—

(1) Are made in writing and signed by one of the following:

(i) The physician.

(ii) The physical therapist who furnishes the physical therapy services.

(iii) The occupational therapist that furnishes the occupational therapy services.

(iv) The speech-language pathologist who furnishes the speech-language pathology services.

(v) A registered professional nurse or a staff physician, in accordance with oral orders from the physician, physical therapist, occupational therapist, or speech-language pathologist who furnishes the services.

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(vi) A nurse practitioner, a clinical nurse specialist, or a physician assistant.

(2) The changes are incorporated in the plan immediately.

[53 FR 6638, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 54 FR 38680, Sept. 20, 1989; 54 FR 46614, Nov. 6, 1989. Redesignated at 56 FR 8854, Mar. 1, 1991; 56 FR 23022, May 20, 1991; 63 FR 58907, Nov. 2, 1998; 67 FR 80040, Dec. 31, 2002; 72 FR 66399, Nov. 27, 2007]

§410.62 Outpatient speech-language pathology services: Conditions and exclusions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(ii) of this section, Medicare Part B pays for outpatient speech-language pathology services only if they are furnished by an individual who meets the qualifications for a speech-language pathologist in §484.4 of this chapter and only under the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine or osteopathy.

(2) They are furnished under a written plan of treatment that meets the requirements of §410.61.

(3) They are furnished by one of the following:

(i) A provider as defined in §489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider.

(ii) A speech-language pathologist in private practice as described in paragraph (c) of this section.

(iii) Incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services under State law. When a speech-language pathology service is provided incident to the services of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to speech-language pathology and speech-language pathologists, except that a license to practice speech-

language pathology services in the State is not required.

(b) *Special Condition for coverage of outpatient speech-language pathology services furnished to certain inpatients of a hospital, CAH, or SNF provisions for services furnished by speech-language pathologists in private practice.* Medicare Part B pays for outpatient speech-language pathology services furnished to an inpatient of a hospital, CAH, or SNF who requires the services but has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) *Special provisions for services furnished by speech-language pathologists in private practice—(1) Basic qualifications.* In order to qualify under Medicare as a supplier of outpatient speech-language pathology services, each individual speech-language pathologist in private practice must meet the following requirements:

(i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of speech-language pathology by the State in which he or she practices, and practice only within the scope of his or her license and/or certification.

(ii) Engage in the private practice of speech-language pathology as an individual, in one of the following practice types:

(A) An unincorporated solo practice.

(B) An unincorporated partnership or unincorporated group practice.

(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated speech-language pathology practice.

(D) An employee of a physician group.

(E) An employee of a group that is not a professional corporation.

(iii) Bill Medicare only for services furnished in one of the following:

(A) A speech-language pathologist's private practice office space that meets all of the following:

(1) 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 and during the hours that the therapist engages in practice at that location.

(2) The space must be owned, leased, or rented by the practice, and used for

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

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(Rev. 108, 07-31-09)

(Rev. 116, 12-11-09)

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220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services (Rev. 63, Issued: 12-29-06, Effective: 01-01-07, implementation: on or before 01-29-07)

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

A. General

To be covered, services must be skilled therapy services as described in this chapter and be rendered under the conditions specified. Services provided by professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services. Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed.

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

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

B. Reasonable and Necessary

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

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:
 - o Medicare manuals (such as this manual and Publications 100-03 and 100-04),
 - o Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database:<http://www.cms.hhs.gov/mcd>, and
 - o Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.
- While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See item C for descriptions of skilled (rehabilitative) services.
- There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

NOTE: Claims for therapy services denied because they are not considered reasonable and necessary are excluded by §1862(a)(1) of the Act and are thus subject to consideration under the waiver of liability provision in §1879 of the Act.

C. Rehabilitative Therapy

Description of Rehabilitative Therapy. The concept of rehabilitative therapy includes recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, or decrease in severity, or rationalization for an optimistic outlook to justify continued treatment.

Covered therapy services shall be rehabilitative therapy services unless they meet the criteria for maintenance therapy requiring the skills of a therapist described below. Rehabilitative therapy services are skilled procedures that may include but are not limited to:

Evaluations; reevaluations

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

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

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

Instruction leading to establishment of compensatory skills;

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

Patient and family training to augment rehabilitative treatment or establish a maintenance program. Education of staff and family should be ongoing through treatment and instructions may have to be modified intermittently if the patient's status changes.

Skilled Therapy. Rehabilitative therapy occurs when the skills of a therapist, (See definition of therapist in section 220 of this chapter) are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. (See also section 220.3 of this chapter for documenting skilled therapy.)

Skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to

improve the patient's condition. In the case of a progressive degenerative disease, for example, service may be intermittently necessary to determine the need for assistive equipment and establish a program to maximize function. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel without the supervision of qualified professionals.

Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services. If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, or does not legitimately require the services of a qualified professional for management of a maintenance program as described below, the services will no longer be considered reasonable and necessary. Services that are not reasonable or necessary should be excluded from coverage under §1862(a)(1) of the Act.

Potential for Improvement Due to Treatment. If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, therapy would not be covered because it is not considered rehabilitative or reasonable and necessary.

Improvement is evidenced by successive objective measurements whenever possible (see objective measurement instruments for evaluation in the §220.3.C of this chapter).

Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered. (See exceptions for maintenance in §220.2D of this manual).

D. Maintenance Programs

During the last visits for rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized skill, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.

Where a maintenance program is not established until after the rehabilitative therapy program has been completed (and the skills of a therapist are not necessary) development of a maintenance program would not be considered reasonable and necessary for the treatment of the

patient's condition. It would be excluded from coverage under §1862(a)(1) of the Act unless the patient's safety was at risk (see below).

EXAMPLE: A Parkinson patient who has been under a rehabilitative physical therapy program may require the services of a therapist during the last week or two of treatment to determine what type of exercises will contribute the most to maintain the patient's present functional level following cessation of treatment. In such situations, the design of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist, the instruction of the patient or family members in carrying out the program, and such infrequent reevaluations as may be required would constitute covered therapy because of the need for the skills of a qualified professional.

Evaluation and Maintenance Plan without Rehabilitative Treatment. After the initial evaluation of the extent of the disorder, illness, or injury, if the treating qualified professional determines the potential for rehabilitation is insignificant, an appropriate maintenance program may be established prior to discharge. Since the skills of a therapist are required for the development of the maintenance program and training the patient or caregivers, this service is covered.

EXAMPLE: The skills of a qualified speech-language pathologist may be covered to develop a maintenance program for a patient with multiple sclerosis, for services intended to prevent or minimize deterioration in communication ability caused by the medical condition, when the patient's current medical condition does not yet justify the need for the skilled services of a speech-language pathologist. Evaluation, development of the program and training the family or support personnel would require the skills of a therapist and would be covered. The skills of a therapist are not required and services are not covered to carry out the program.

Skilled Maintenance Therapy for Safety. If the services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may be necessary for the safe and effective delivery of such services. When the patient's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

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