DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

FACT SHEET

Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to outpatient rehabilitation therapy services and provides information on the documentation needed to support a claim submitted to Medicare for outpatient rehabilitation therapy services.

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) error rate, as required by the Improper Payments Information Act. CERT randomly selects a small sample of Medicare FFS claims and reviews those claims and medical records from providers/suppliers who submitted the claims for compliance with Medicare coverage, coding, and billing rules.

In order to accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims error rate and a provider compliance error rate. The results of the reviews are published in an annual report and semi-annual updates.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare trust funds and protect patients.

Errors Identified Through the CERT Review Process

CERT identified the following issues with outpatient rehabilitation therapy services:

- Missing/incomplete plan of care/treatment plan;
- Missing physician/Non-Physician Practitioner (NPP) signatures and dates;
- Missing total time for procedures and modalities; and
- Missing certification and recertification.

Documentation of Outpatient Rehabilitation Therapy Services Specific to the CERT Findings

Written Treatment Plan/Plan of Care

Outpatient rehabilitation therapy services must relate directly and specifically to a written treatment plan (also known as the plan of care or plan of treatment). The plan of care must be established before treatment begins, with some

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minor exceptions. The plan of care is established when it is developed (i.e., written **or** dictated).

The plan of care is established by a physician, an NPP, a physical therapist, an occupational therapist, or a speech-language pathologist.

The plan of care, at a **minimum**, should contain:

- Diagnoses;
- Long-term treatment goals;
- Type of rehabilitation therapy services (physical therapy, occupational therapy, or speech-language pathology) – identifies each specific intervention, procedure or modality, in order to support billing and verify correct coding;
- Amount of therapy – number of treatment sessions in a day;
- Duration of therapy – number of weeks or number of treatment sessions; and
- Frequency of therapy – number of treatment sessions in a week.

The signature and professional identity of the person who established the plan of care and the date it was established must be recorded with the plan of care. If significant changes need to be made to the plan of care, the physician/NPP certification is required.

The plan of care should provide for treatment in the most effective and efficient manner for the best achievable outcome.

Initial Certification of the Plan of Care

The physician's/NPP's certification (with or without an order) satisfies all of the certification requirements for the duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.

Timely certification of the initial plan of care is met when the physician/NPP certification of the plan of care is documented, by signature or verbal order, and dated within 30 days following the first day of treatment (including evaluation). Verbal orders must be followed within 14 days by a signature and date.

Recertification

Recertification documenting the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan of care becomes evident, or at least every 90 days after initiation of treatment under the plan of care, unless the certification is delayed. Recertification is required sooner when the duration of the plan of care is less than 90 days.

Billing Procedure/Modality Units

Many Healthcare Common Procedure Coding System (HCPCS) codes where the procedure is not defined by a specific time frame (untimed), are reported using "1" in the unit field (e.g., HCPCS codes for therapy evaluations, group therapy, and supervised

modalities). However, a few untimed codes, "add-on" codes for example, are reported based on the number of times the procedure is performed (e.g., an add-on HCPCS debridement code is billed, in addition to its "base" code, for each additional 20 square centimeters of tissue removed).

Some HCPCS codes specify that direct (one-on-one) time spent in patient contact is 15 minutes. In those cases, the units are the appropriate number of 15-minute units of services. When only one service is provided in a day, a service performed for less than eight minutes should not be billed. When more than one unit of service is provided, the initial and subsequent services must total at least 15 minutes, and the last unit may be counted as a full unit of service if at least eight minutes of additional service has been furnished.

Total treatment minutes of the patient, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented.

Avoid CERT Errors

In order to avoid a CERT error, check your medical record documentation and claims submission practices to ensure you:

- Create a complete plan of care, making certain to include your signature, professional identification (e.g., PT, OTR/L), and date the plan was established;
- Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met;
- Confirm the plan of care is certified (recertified when appropriate) with physician/NPP signature and date; and
- Clearly document, in minutes, the total treatment time for the timed codes and the total treatment time (including timed and untimed codes) in the patient's record.

Resources

CMS Internet-Only Manuals (IOMs) provide detailed descriptions of Medicare requirements for outpatient rehabilitation therapy services. Policies concerning providers and suppliers of outpatient rehabilitation therapy services are located in many places throughout the IOMs. Relevant IOM sections that may be of interest are listed below. For more information, visit http://www.cms.gov/Manuals/IOM/list.asp on the CMS website. However, comprehensive knowledge of the policies that apply to outpatient rehabilitation therapy services cannot be obtained through the IOMs alone. The most definitive policies are Local Coverage Determinations found in the Medicare Coverage Database, available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website. For a list of Medicare Contractors, visit http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

For more information on the topics covered in this fact sheet, refer to the following resources:

- **Definitions Related to Therapy Services**

  CMS IOM, Publication (Pub.) 100-02, Chapter 15, Section 220
- **Plan of Care/Treatment Plan**

  CMS IOM, Pub. 100-02, Chapter 15, Section 220.1.2
- **Documentation Requirements**

  CMS IOM, Pub. 100-02, Chapter 15, Section 220.1.3
- **Certification/Recertification**

  CMS IOM, Pub. 100-02, Chapter 15, Section 220.1.3
- **HCPCS Coding Requirements**

  CMS IOM, Pub. 100-04, Chapter 5, Section 20
- **Billing Procedure/Modality Units**

  CMS IOM, Pub. 100-04, Chapter 5, Section 20.2

Information on outpatient rehabilitation therapy services is found in the following primary CMS IOM publications:

- **CMS IOM, Pub. 100-02, "Medicare Benefit Policy Manual"**
  - Chapter 15 – Covered Medical and Other Health Services
    - Section 220 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance
    - Section 230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology
  - Chapter 12 – Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage
- **CMS IOM, Pub. 100-04, "Medicare Claims Processing Manual"**
  - Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services

Information on specific outpatient rehabilitation therapy services topics is found in the following CMS IOM publications and web pages:

- **Group Therapy and Students** – CMS IOM, Pub. 100-02, Chapter 15, Section 230
- **"Under Arrangements" Defined** – CMS IOM, Pub. 100-01, Chapter 5, Section 10.3
- **Local Coverage Determinations** – CMS IOM, Pub. 100-08, "Medicare Program Integrity Manual," Chapter 13
- **Therapy Caps** – CMS IOM, Pub. 100-04, Chapter 5, Sections 10.2-10.5
- **Therapy Services Web Page**
  - An updated list of CMS therapy-related Transmittals and Part B Therapy Billing Scenarios is available at http://www.cms.gov/TherapyServices on the CMS website.
- **List of Therapy Service HCPCS Codes**
  - The annual list of therapy services is available at http://www.cms.gov/TherapyServices on the CMS website.

For more information on outpatient rehabilitation therapy services, contact your local carrier, Fiscal Intermediary (FI), or Medicare Administrative Contractor (AB MAC). Refer to carrier/AB MAC and FI/AB MAC contact information at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website. If your Medicare Contractor cannot assist you, contact the CMS Regional Office. For more information, refer to the CMS Regional Office contact information at http://www.cms.gov/RegionalOffices on the CMS website.