Local Coverage Article:
Billing and Coding: Medical Necessity of Therapy Services (A53304)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	01111 - MAC A	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	01112 - MAC B	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	01182 - MAC B	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	01211 - MAC A	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	01212 - MAC B	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	01311 - MAC A	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	01312 - MAC B	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	01911 - MAC A	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
				Nevada Northern Mariana Islands

Article Information

General Information

Article ID
A53304

Article Title
Billing and Coding: Medical Necessity of Therapy Services

Article Type
Billing and Coding

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Original Effective Date
10/01/2015

Revision Effective Date
04/28/2020

Revision Ending Date
N/A

Retirement Date
N/A

CMS National Coverage Policy

N/A

Article Guidance

Article Text:

Medical records must support medical necessity of therapy services provided e.g., Are the services appropriate for the patient's condition and do the services require the skills and knowledge of a qualified clinician? For detailed guidance, view the CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 220-230. The requirements in these sections describe a standard of care that is anticipated throughout the therapy plan of care for each discipline. To meet Medicare's standard of coverage all of the following requirements must be met.

Qualified Clinician
Therapy services must be provided by a qualified clinician i.e., physician, non-physician practitioner (NPP), therapist, or speech-language pathologist (SLP). Treatment services may also be provided by an appropriately supervised physical therapy (PT) or occupational therapy (OT) assistant. Services provided by a therapy aide with or without qualified clinician supervision are not reimbursable in any therapy setting. For additional information, see the attached *Therapy Students and Aides* article in the Related Local Coverage Documents link below.

Skilled Level of Care
Skill is a level of expertise acquired through specialized training not attained by the general population. While a patient's medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis is never 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 non-skilled personnel after sufficient training.

To demonstrate that services are at a skilled level of care, the medical record must support that the expertise and knowledge of a qualified clinician was necessary and was provided. Documentation needs to clearly indicate the clinician's unique professional contribution to the therapy services e.g., Why did the patient require professional treatment, education or training? What specialized treatment, education or training did the clinician actually provide? How did the patient benefit from the specialized knowledge applied by the clinician?

Skilled land and water-based therapy programs require that the patient have direct one-on-one contact with the qualified clinician throughout the procedure. The services of a qualified clinician cannot be billed for supervising a patient that is independently completing an exercise program. Additionally, ongoing repetitive exercises that do not demonstrate the need for continued hands-on involvement and/or teaching by the qualified clinician would not be considered to be at a skilled level of care. Documentation must support that the therapy sessions are at a level of complexity that requires ongoing qualified clinician input.

Medical Necessity - Rehabilitation
Services must be under accepted standards of medical practice and considered to be specific and effective treatment for the patient's condition. The amount, frequency, and duration of the services planned and provided must be reasonable. Services must be necessary for treatment of the patient's condition: The medical record must clearly describe the patient's condition before, during, and after the therapy episode to support that the patient significantly benefitted from ongoing therapy services and that the progress was sustainable and of practical value when measured against the patient's condition at the start of treatment. Documentation of comparable objective/functional measures plays a key role in demonstrating medical necessity.

Example of acceptable and unacceptable comparative measures:

- *Acceptable* comparative measure: At the time of the initial evaluation it was documented that the patient had an objective manual muscle test (MMT) of 3/5 for right knee extension. Documentation in the 10 day progress report supported that the patient had achieved 4/5 for right knee extension which demonstrated significant benefit for the patient.
- *Unacceptable* comparative measure: At the time of the 10 day progress report the documentation supported that the patient had an objective MMT of 4/5 for right biceps flexion. At the time of the 20 day progress report documentation supported that the patient was able to complete 3 sets of 10 repetitions for right biceps flexion during each therapy visit. Since the MMT information is not directly comparable to the therapeutic exercise sets and repetitions this comparison does not clearly demonstrate ongoing significant benefit for the patient and may result in denial.

These objective/functional measures must minimally be established for the patient's prior level of function (PLOF), status at the initial evaluation, and status at each progress reporting interval. Qualified clinicians must complete the progress reports a minimum of every ten treatment days throughout the episode of care. The progress reporting interval does not match the interval for physician certification of therapy services which may extend up to 90 calendar days.

Successful rehabilitation therapy requires the attainment of significant progress for a reasonable period of time beyond the immediate intervention. Services should not be repetitive, palliative, or simply reinforcing previously learned skills or maintaining function. In most instances, the goal of therapy is to maximize patient/caregiver abilities within the patient's home environment. It is expected that the patient's treatment goals and achievements during the therapy episode will reflect significant and timely progress toward this end. As a result, during the therapy episode, the emphasis of therapy will generally shift from traditional, patient-centered therapeutic services to patient/caregiver education in order to prepare the patient for a safe transition to an effective maintenance program. The expectation is that the patient/caregiver will be compliant in performing the established maintenance program to help prevent relapse. If therapeutic gains from prior therapy services are tenuous, such that additional concentrated therapy is needed for non-skilled maintenance of the patient in their usual living environment (that includes caregivers), then the goals of additional therapy would be considered to be unrealistic.

Medical Necessity - Maintenance
Medicare reimburses for the development of a medically necessary individualized maintenance program to:

- Maximize and retain the patient's functional status achieved with therapy services;
- Assure patient safety within their home environment;
- Train the patient and/or caregiver in the maintenance activities;
- Prevent further decline in the patient's condition.

Medicare does not reimburse for carrying out maintenance activities when:

- The activities do not require the skills of a qualified clinician i.e., the level of complexity and sophistication of the activities do not require the performance and/or supervision of a therapist.
- The condition of the patient is such that the services do not require the performance and/or supervision of a therapist.
- The activities can reasonably be provided by non-skilled personnel after training is completed by the qualified clinician.

It is anticipated that once the maintenance program is established, updates to the program will be necessary on an infrequent basis.

When additional medical necessary services are required for the same medical condition, a thorough initial evaluation should be completed for the patient who was previously discharged. Documentation for maintenance program revisions must support that any additional therapy services require the performance and/or supervision of a qualified therapist due to the complexity/sophistication of the required procedures and/or the condition of the patient. The documentation must clearly indicate why a revision of the maintenance program is necessary and what specific revision(s) are needed. Key documentation components include:

- Was the patient/caregiver compliant with their previously established maintenance program?
- Was the patient unable to complete the maintenance program? Why?

Are there any new significant medical and/or functional issues noted since discharge from prior therapy that necessitate revision of the maintenance program?

For additional information, see the attached *Therapy Evaluation and Assessment* article in the Related Local Coverage Documents link below

Sources

- **Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Manual (RAI) Version 3, Section O**
- **CMS Inpatient Rehabilitation Facility (IRF) Training Q&A Series 4 Section V, #33**
- **IOM, Medicare Benefit Policy Manual, Publication 100-02, Chapter 1, Section 110**
- **IOM, Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Sections 220-230.**

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
97161	PHYSICAL THERAPY EVALUATION: LOW COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY WITH NO PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEM(S) USING STANDARDIZED TESTS AND MEASURES ADDRESSING 1-2 ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; A CLINICAL PRESENTATION WITH STABLE AND/OR UNCOMPLICATED CHARACTERISTICS; AND CLINICAL DECISION MAKING OF LOW COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 20 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97162	PHYSICAL THERAPY EVALUATION: MODERATE COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY OF PRESENT PROBLEM WITH 1-2 PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEMS USING STANDARDIZED TESTS AND MEASURES IN ADDRESSING A TOTAL OF 3 OR MORE ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; AN EVOLVING CLINICAL PRESENTATION WITH CHANGING CHARACTERISTICS; AND CLINICAL DECISION MAKING OF MODERATE COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97163	PHYSICAL THERAPY EVALUATION: HIGH COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY OF PRESENT PROBLEM WITH 3 OR MORE PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEMS USING STANDARDIZED TESTS AND MEASURES ADDRESSING A TOTAL OF 4 OR MORE ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; A CLINICAL PRESENTATION WITH UNSTABLE AND UNPREDICTABLE CHARACTERISTICS; AND CLINICAL DECISION MAKING OF HIGH COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 45 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97165	OCCUPATIONAL THERAPY EVALUATION, LOW COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY HISTORY, WHICH INCLUDES A BRIEF HISTORY INCLUDING REVIEW OF MEDICAL AND/OR THERAPY RECORDS RELATING TO THE PRESENTING PROBLEM; AN ASSESSMENT(S) THAT IDENTIFIES 1-3 PERFORMANCE DEFICITS (IE, RELATING TO PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL SKILLS) THAT RESULT IN ACTIVITY LIMITATIONS AND/OR PARTICIPATION RESTRICTIONS; AND CLINICAL DECISION MAKING OF LOW COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE OCCUPATIONAL PROFILE, ANALYSIS OF DATA FROM PROBLEM-FOCUSED ASSESSMENT(S), AND CONSIDERATION OF A LIMITED NUMBER OF TREATMENT OPTIONS. PATIENT PRESENTS WITH NO COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE.

CODE	DESCRIPTION
	MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NOT NECESSARY TO ENABLE COMPLETION OF EVALUATION COMPONENT. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97166	OCCUPATIONAL THERAPY EVALUATION, MODERATE COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY HISTORY, WHICH INCLUDES AN EXPANDED REVIEW OF MEDICAL AND/OR THERAPY RECORDS AND ADDITIONAL REVIEW OF PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL HISTORY RELATED TO CURRENT FUNCTIONAL PERFORMANCE; AN ASSESSMENT(S) THAT IDENTIFIES 3-5 PERFORMANCE DEFICITS (IE, RELATING TO PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL SKILLS) THAT RESULT IN ACTIVITY LIMITATIONS AND/OR PARTICIPATION RESTRICTIONS; AND CLINICAL DECISION MAKING OF MODERATE ANALYTIC COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE OCCUPATIONAL PROFILE, ANALYSIS OF DATA FROM DETAILED ASSESSMENT(S), AND CONSIDERATION OF SEVERAL TREATMENT OPTIONS. PATIENT MAY PRESENT WITH COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE. MINIMAL TO MODERATE MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NECESSARY TO ENABLE PATIENT TO COMPLETE EVALUATION COMPONENT. TYPICALLY, 45 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
97167	OCCUPATIONAL THERAPY EVALUATION, HIGH COMPLEXITY, REQUIRING THESE COMPONENTS: AN OCCUPATIONAL PROFILE AND MEDICAL AND THERAPY HISTORY, WHICH INCLUDES REVIEW OF MEDICAL AND/OR THERAPY RECORDS AND EXTENSIVE ADDITIONAL REVIEW OF PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL HISTORY RELATED TO CURRENT FUNCTIONAL PERFORMANCE; AN ASSESSMENT(S) THAT IDENTIFIES 5 OR MORE PERFORMANCE DEFICITS (IE, RELATING TO PHYSICAL, COGNITIVE, OR PSYCHOSOCIAL SKILLS) THAT RESULT IN ACTIVITY LIMITATIONS AND/OR PARTICIPATION RESTRICTIONS; AND CLINICAL DECISION MAKING OF HIGH ANALYTIC COMPLEXITY, WHICH INCLUDES AN ANALYSIS OF THE PATIENT PROFILE, ANALYSIS OF DATA FROM COMPREHENSIVE ASSESSMENT(S), AND CONSIDERATION OF MULTIPLE TREATMENT OPTIONS. PATIENT PRESENTS WITH COMORBIDITIES THAT AFFECT OCCUPATIONAL PERFORMANCE. SIGNIFICANT MODIFICATION OF TASKS OR ASSISTANCE (EG, PHYSICAL OR VERBAL) WITH ASSESSMENT(S) IS NECESSARY TO ENABLE PATIENT TO COMPLETE EVALUATION COMPONENT. TYPICALLY, 60 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.

CPT/HCPCS Modifiers

N/A

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
04/28/2020	R4	Changed the effective date to 04/28/2020 to be consistent with the date this article was converted to a Billing and Coding article. Clarified the first paragraph by adding 'plan of care for each' to the statement "The requirements in these sections describe a standard of care that is anticipated throughout the therapy plan of care for each discipline." Added the Heading "Example of acceptable and unacceptable comparative measures" to make the section stand out more corrected the formatting of the examples and delete the procedure codes with the descriptions from the Article Text.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		Added 97161, 97162, 97163, 97165, 97166 and 97167 to the CPT Codes section so the descriptions will display.
01/01/2017	R3	Article converted to Billing and Coding, no change in coverage made.
01/01/2017	R2	04/30/18-Corrected the hyperlinks to the *Therapy Students and Aides* and *Therapy Evaluation and Assessment* articles noted in the article text.
01/01/2017	R1	This article is revised to change the initial PT/OT evaluation codes to 97162-97163 for PT and 97165-97167 for OT effective 01/01/2017. Also, this article now combines JEA A53303 into the JEB article A53304 so that both JEA and JEB contract numbers will have the same final MCD article number as JEB A53304. Deleted CPT codes 97001 & 97003.

Associated Documents

Related Local Coverage Document(s)

Article(s)

A53309 - Billing and Coding: Therapy Evaluation, Re-Evaluation and Formal Testing

A53339 - Billing and Coding: Therapy Students and Aides

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

http://
http://
Medicare Benefit Policy Manual, Publication 100-02, Chapter 1, Section 110
Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Sections 220-230.
http://

Other URL(s)

N/A

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