

Local Coverage Article: 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	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern American Samoa
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	Guam Hawaii Northern Mariana Islands American Samoa
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada American Samoa California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	Guam Hawaii Nevada Northern Mariana Islands

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Article Information

General Information

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A53304

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10/01/2015

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Medical Necessity of Therapy Services

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01/01/2017

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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 disciplines. 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.

- *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, i.e. CPT® 97161 - Physical therapy evaluation: low complexity, typically, 20 minutes are spent face-to-face with the patient and/or family, 97162 - Physical therapy evaluation: moderate complexity, typically, 30 minutes are spent face-to-face with the patient and/or family or 97163 - Physical therapy evaluation: high complexity, typically, 45 minutes are spent face-to-face with the patient and/or family for initial Physical Therapy evaluation and 97165 - Occupational therapy evaluation, low complexity, typically, 30 minutes are spent face-to-face with the patient and/or family, 97166 - Occupational therapy evaluation, moderate complexity, typically, 45 minutes are spent face-to-face with the patient and/or family or 97167 - Occupational therapy evaluation, high complexity, typically, 60 minutes are spent face-to-face with the patient and/or family, for Occupational Therapy, 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? e.g., Patient requires a caregiver to complete the program, but no caregiver was present in the living environment.
- 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.**

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Coding Information

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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article 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

CPT/HCPCS Codes Group 1 Paragraph:

97161

97162

97163

97165

97166

97167

Group 1 Codes: N/A

Group 1 CPT/HCPCS Code Group 1 CPT/HCPCS Code Description

ICD-10 Codes that are Covered N/A

ICD-10 Codes that are Not Covered N/A

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R2	04/30/18-Corrected the hyperlinks to the <i>Therapy Students and Aides</i> and <i>Therapy Evaluation and Assessment</i> 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.

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A53309 - Therapy Evaluation and Assessment Services](#) [A53339 - 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) N/A

Other URL(s) N/A

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Keywords

- 97161
- 97162
- 97163
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- 97166
- 97167
- Medical
- Necessity
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- Maintenance

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