Coverage Summary

Rehabilitation: Medical Rehabilitation (OT, PT and ST, including Cognitive Rehabilitation)

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<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 08/15/2017</td>
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Related Medicare Advantage Policy Guidelines:

- Diathermy Treatment (NCD 150.5)
- Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (NCD 150.8)
- Melodic Intonation Therapy (NCD 170.2)
- Speech-Language Pathology Services for the Treatment of Dysphagia (NCD 170.3)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

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I. COVERAGE

Coverage Statement: Medical rehabilitation (occupational therapy, physical therapy, speech-language pathology, including cognitive rehabilitation) is covered when Medicare coverage criteria are met.

Guidelines/Notes:

1. Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy and Speech-Language Pathology Services)
   a. General
      To be covered, services must be skilled therapy services 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. A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

Skilled therapy services may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition. For further information see #1.c (Rehabilitative Services) and #1.d (Maintenance Programs) below.

Services that do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions as 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 provided by staff who are not qualified or appropriately supervised, are not payable therapy services.

b. Reasonable and Necessary
   To be considered reasonable and necessary, each of the following conditions must be met.
   1) The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the member’s condition.

Note: Acceptable practices for therapy services are found in:
- Medicare manuals (such as Publications 100-2, 100-03 and 100-04),
- Local Coverage Determinations, and
- Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology
The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated). See the Medicare Benefit Policy Manual, Chapter 15, §220.1.2 - Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services. (Accessed May 4, 2017)

2) The services shall be of such a level of complexity and sophistication or the condition of the member 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. Medicare coverage does not turn on the presence or absence of a beneficiary’s potential for improvement from the therapy, but rather on the beneficiary’s need for skilled care. For additional guidance, see #1.d (Maintenance Programs) below.

3) If the Health Plan 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, the Health Plan shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing a claim, the Health Plan finds that services were not furnished under proper supervision, the claim shall be denied.

4) While a member’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a member’s diagnosis or prognosis cannot 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.

5) 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.


c. Rehabilitative Therapy

Rehabilitative therapy includes services designed to address 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, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive objective measurements whenever possible (see objective measurement and other instruments for evaluation in the §220.3.C of this chapter). If an individual’s expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve
such potential, rehabilitative therapy is not reasonable and necessary. Rehabilitative therapy services are skilled procedures that may include but are not limited to:

- Evaluations and 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
- Training of patient and family to augment rehabilitative treatment. Training of staff and family should be ongoing throughout treatment and instructions modified intermittently as the patient’s status changes.

Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. 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.

Rehabilitative therapy may be needed, and improvement in a patient’s condition may occur, even when a chronic, progressive, degenerative, 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 or to maximize his/her functional abilities. 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.

Rehabilitative therapy is not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary and generalized weakness, which may follow a brief period of bed rest following surgery) that 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.

If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, the services will no longer be considered reasonable and necessary under this section. (See #1.d for additional covered therapy benefits under Maintenance Program). Services that are not reasonable or necessary are excluded from coverage under §1862(a)(1)(A) of the Act.

d. Maintenance Program

Maintenance program is a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration
due to a disease or illness.

Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

Coverage for skilled therapy services related to a reasonable and necessary maintenance program is available in the following circumstances:

- **Establishment or design of maintenance programs.** If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.

- **Delivery of maintenance programs.** Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary’s need for skilled care. A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided. However, skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program. Such skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the therapy procedures required to maintain the patient’s current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or (b) the particular patient’s special medical complications require the skills of a qualified therapist to furnish a therapy service required maintain the patient’s current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures. Unlike coverage for rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient’s potential for improvement from the therapy.

For specific examples how to analyze and determine coverage, see the Medicare Benefit Policy Manual, Chapter 15, §220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services, D-Maintenance Programs. (Accessed May 4, 2017)


e. **Documentation Requirements for Therapy Services**

To be payable, the medical record and the information on the claim form must consistently and accurately report covered therapy services, as documented in the medical record. Documentation must be legible, relevant and sufficient to justify the
services billed. In general, services must be covered therapy services provided according to Medicare requirements. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all requirements applicable to Medicare claims.

For more detailed documentation requirements, refer to the Medicare Benefit Policy Manual, Chapter 15, §220.3 - Documentation Requirements for Therapy Services. (Accessed May 4, 2017)

f. Outpatient rehabilitation services maybe covered in the following settings:

1) Comprehensive Outpatient Rehabilitation Facility (CORF)

   Note: A single, home environment evaluation visit is a covered CORF service if it is included in the physical therapy, occupational therapy or speech-language pathology plan of treatment.

Required Services

A CORF must furnish at least the following:

- CORF physicians’ services - includes professional services performed by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs services. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12, §80.1. (Accessed May 4, 2017)
- Physical therapy services - include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual Chapter 12 §40.1. (Accessed May 4, 2017)
- Social and/or psychological services - are covered only if the patient’s physician or the CORF physician establishes that the services directly relate to the patient’s rehabilitation plan of treatment and are needed to achieve the goals in the rehabilitation plan of treatment. Social and/or psychological services include only those services that address the patient’s response and adjustment to the rehabilitation treatment plan; rate of improvement and progress towards the rehabilitation goals, or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment being provided to the patient. CORF social and/or psychological services do not include services for mental health diagnoses. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12 §40.1. (Accessed May 4, 2017)

Optional Services

The CORF may provide any or all of the following rehabilitation services:

- Occupational therapy-services include assessment of an individual’s level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12 §40.1. (Accessed May 4, 2017)
• Speech-Language pathology-services for the diagnosis and treatment of speech and language disorders that create difficulties in communication or dysphagia (swallowing difficulties). See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12 §40.1 (Accessed May 4, 2017)

• Respiratory therapy - services includes only those services that can be appropriately provided to CORF patients by a qualified respiratory therapist. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual Chapter 12 §40.1, (Accessed May 4, 2017)

• Prosthetic and orthotic devices - includes testing, fitting, or training in the use of such devices. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12 §40.1. (Accessed May 4, 2017)

• Nursing – includes nursing services (e.g., teaching self catheterization) that directly relate to and are specified in the rehabilitation plan of treatment, are necessary for the attainment of the rehabilitation goals and are provided by a registered nurse. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12 §40.1 (Accessed May 4, 2017)

• A single physical therapy, occupational therapy, or speech-language pathology home environment evaluation visit as appropriate – this includes evaluating the potential impact of the home environment on the rehabilitation goals. See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12 §40.1. (Accessed May 4, 2017)


3) Member’s place of residence; see the Coverage Summary for Home Health Services and Home Health Visits

g. Therapy Caps

Although CMS implemented Therapy Caps effective January 1, 2006, this change does not affect the UnitedHealthcare MedicareComplete or UnitedHealthcare MedicareDirect plans.

For Medicare information regarding therapy caps, see the Medicare Claims Processing Manual, Chapter 5, §10.2 - The Financial Limitation Therapy Caps. (Accessed May 4, 2017)

Local Coverage Determinations (LCDs) exist and compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed May 4, 2017)

2. Inpatient Rehabilitation Services

a. Inpatient Rehabilitation Facility (IRF) Services

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive
rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary if the patient meets all of the requirements. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.23 (b)(2) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each patient’s individual care needs.


For the list of medical conditions and facility requirements for intensive rehabilitative services, see the CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements. (Accessed May 4, 2017)

IRF Medical Necessity Criteria

In order for IRF care to be considered reasonable and necessary, the documentation in the patient’s IRF medical record (which must include the preadmission screening the post-admission physician evaluation, the overall plan of care and the admission orders) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

1) The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

2) The patient must generally require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.

3) The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The patient can only be expected to benefit significantly from
the intensive rehabilitation therapy program if the patient’s condition and functional status are such that the patient can reasonably be expected to make **measurable improvement** (that will be of practical value to improve the patient’s functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time. The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard.

4) The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. **The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient’s stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient’s capacity to benefit from the rehabilitation process.**

5) The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation. (See **Definition Section for the description of Interdisciplinary Team Approach**.)

See the **Medicare Benefit Policy Manual, Chapter 1, §110.2 Inpatient Rehabilitation Facility Medical Necessity Criteria.** (Accessed May 4, 2017)

**Notes:**

- **Definition of Measurable Improvement:**
  A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient’s IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient’s functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient’s safe return to the home or community-based environment upon discharge from the IRF. The patient’s IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

  Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient’s admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

  For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care or return to his or her prior level of functioning. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient’s ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and an inter-disciplinary team approach to care (as defined in section 110.2.2). Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. Since in most instances the goal of an IRF stay is to enable a patient’s safe return to the home or community-based environment upon discharge, the patient’s
treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.

CMS notes that as evidenced by the criteria established above, an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.

See the Medicare Benefit Policy Manual, Chapter 1, §110.3 - Definition of Measurable Improvement. (Accessed May 4, 2017)

- **Required Preadmission Screening:**

  A preadmission screening is an evaluation of the patient’s condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient’s medical and functional status within the **48 hours immediately preceding the IRF admission** in the patient’s medical record at the IRF. The preadmission screening in the patient’s IRF medical record serves as the primary documentation by the IRF clinical staff of the patient’s status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive. The preadmission screening documentation, and begin development of the patient’s expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care (as discussed in section 110.1.3). The postadmission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and must include a documented history and physical exam, as well as a review of the patient’s prior and current medical and functional conditions and comorbidities.

  In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the **first 24 hours of admission to the IRF** and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient’s medical record at the IRF. See the Medicare Benefit Policy Manual, Chapter 1, §110.1.2 - Required Post-Admission Physician Evaluation. (Accessed May 4, 2017)

  For the list of medical conditions and facility requirements for intensive rehabilitative services, see the CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements (Accessed May 4, 2017)

  b. **Skilled Nursing Facility;** see the Coverage Summary for Skilled Nursing Facility (SNF) Care and Exhaustion of SNF Benefits
Local Coverage Determinations (LCDs) exist and compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed May 4, 2017)

3. **Cognitive Therapy**

In addition to the three required core CORF services, the CORF may furnish any of the other covered and medically necessary items and services listed in the Medicare Benefit Policy Manual, Chapter 12 §20.2. (Accessed May 4, 2017)

These optional services must directly relate to, and be consistent with, the rehabilitation plan of treatment, and must be necessary to achieve the patient’s rehabilitation goals. When a CORF provides occupational therapy, speech-language pathology and/or respiratory therapy services in addition to the required physical therapy services, the physical therapy services shall represent the predominate rehabilitation service provided.

_for discussion of payment rules; see the Medicare Benefit Policy Manual, Chapter 12 §30.1._ (Accessed May 4, 2017)

For occupational therapy, services include assessment of an individual’s level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities. See the 42CFR410.100(c) and the Medicare Benefit Policy Manual, Chapter 12 §40.3. (Accessed May 4, 2017)

**For CORF, required and optional services, refer to #2.b above.**

Local Coverage Determinations (LCDs) which address the development of cognitive skills (CPT 97532) exist and compliance with these policies is required where applicable. These LCDs at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed May 4, 2017)

4. **Melodic Intonation Therapy**

Melodic intonation therapy is covered service only for nonfluent aphasic patients unresponsive to conventional therapy, and the conditions for coverage of speech pathology services are met. See the NCD for Melodic Intonation Therapy (170.2) (Accessed May 4, 2017)

5. **Passive Rehabilitation Therapy for Mandibular Hypomobility**

- Medicare does not have a National Coverage Determination (NCD) for Passive Rehabilitation Therapy for Mandibular Hypomobility.
- Local Coverage Determinations (LCDs) do not exist at this time.
- For coverage guidelines, refer to the UnitedHealthcare Medical Policy for Temporomandibular Joint Disorders

_(IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy.)_  
- **Committee approval date:** May 16, 2017  
- **Accessed May 4, 2017**

6. **Comprehensive Computer-Based Motion Analysis (CPT codes 96000, 96001, 96002, 96003 & 96004)**

- Medicare does not have a National Coverage Determination (NCD) for Comprehensive Computer-based Motion Analysis.
7. **Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)** (CPT code 93668)

*Note: CMS has determined that the National Coverage Determination requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2017 and 2018 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans.*

Supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is covered based on the following guideline outlined in the *Decision Memo for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CAG-00449N)*:

Effective for services performed on or after May 25, 2017, CMS has determined that the evidence is sufficient to cover supervised exercise therapy (SET) is for beneficiaries with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12 week period are covered if all of the following components of a SET program are met:

The SET program must:

- consist of sessions lasting 30-60 minutes comprising a therapeutic exercise-training program for PAD in
- patients with claudication;
  - be conducted in a hospital outpatient setting, or a physician’s office;
  - be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are
- trained in exercise therapy for PAD; and
  - be under the direct supervision of a physician (as defined in 1861(r)(1)), physician assistant, or nurse
- practitioner/clinical nurse specialist (as identified in 1861(aa)(5)) who must be trained in both basic and
- advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

Medicare Administrative Contractors (MACs) have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of
time. A second referral is required for these additional sessions.

SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary physician.

8. **Examples of covered rehabilitation therapy services include, but are not limited to:**
   a. Range of motion tests
   b. Gait training
   c. Therapeutic exercises
   d. Aqua/pool therapy/hydrotherapy only as part of an authorized physical therapy treatment plan conducted by a licensed physical therapist with the therapist in attendance.
      
      *For descriptions of aquatic therapy in a community center pool; see the Medicare Benefit Policy Manual, Chapter 15, §220C - General. (Accessed May 4, 2017)*

   e. Fluidized therapy (fluidotherapy) as a part of an authorized physical therapy treatment plan for the treatment of acute or subacute, traumatic or nontraumatic, musculoskeletal disorders of the extremities. *See the NCD for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (150.8)* (Accessed May 4, 2017)

   f. Treatment of Dysphagia: Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability. *See the NCD for Speech Language Pathology Services for the Treatment of Dysphagia (170.3)* (Accessed May 4, 2017)
      
      *For electrical stimulation for the treatment of dysphagia, see the Coverage Summary for Stimulators: Electrical and Spinal Cord Stimulators.*

9. **Examples of rehabilitation services that are not covered or with limited coverage, include but are not limited to:**
   a. Diathermy Treatment (CPT code 97024 and 97035)
      1) High energy pulsed wave diathermy machines have been found to produce some degree of therapeutic benefit for essentially the same conditions and to the same extent as standard diathermy. Accordingly, where the contractor’s medical staff has determined that the **pulsed wave diathermy** apparatus used is one which is considered therapeutically effective, the treatments are considered a **covered service**, but only for those conditions for which **standard diathermy** is medically indicated and only when rendered by a physician or incident to a physician’s professional services. *See the NCD for Diathermy Treatment (150.5).* (Accessed May 4, 2017)
      2) Heat treatment, including the use of diathermy and ultrasound for pulmonary conditions are **not covered**. There is no physiological rationale or valid scientific documentation of effectiveness of diathermy or ultrasound heat treatments for asthma, bronchitis, or any other pulmonary condition and for such purpose this treatment cannot be considered reasonable and necessary. *See the NCD for Heat Treatment, Including the Use of Diathermy and Ultra-Sound for Pulmonary Conditions (240.3).* (Accessed May 4, 2017)

   - **Home Health Physical Therapy**
- Medicine: Occupational Therapy-Outpatient
- Outpatient Occupational Therapy
- Outpatient Physical and Occupational Therapy Services
- Outpatient Physical Therapy
- Physical Medicine & Rehabilitation Services, Physical Therapy and Occupational Therapy
- Therapy and Rehabilitation Services
- Therapy Services (PT, OT, SLP)

(Accessed May 4, 2017)

b. Massage therapy, unless it is part of a multi-modality authorized treatment plan appropriate to the patient's diagnosis plan with a licensed therapist in attendance. See the Medicare Benefit Policy Manual, Chapter 15, §230.5 - Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP). (Accessed May 4, 2017)

c. Vocational and prevocational assessment and training related solely to specific employment opportunities, work skills or work settings. See the Medicare Benefit Policy Manual, Chapter 15, §230.2 - Practice of Occupational Therapy, D-Application of Medicare Guidelines to Occupational Therapy Services. (Accessed May 4, 2017)


e. Activities that provide a diversion or general motivation. See the Medicare Benefit Policy Manual, Chapter 15, §220.2-Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General. (Accessed May 4, 2017)


II. DEFINITIONS

**Fluidized therapy (Fluidotherapy):** High intensity heat modality consisting of a dry whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having the properties of a liquid. NCD for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (150.8). (Accessed May 4, 2017)

**Individual Patient Care Plan (Overall Care Plan):**
Information from the preadmission screening and the post-admission physician evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient’s medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care must include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical,
occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient’s course of treatment must be based on consideration of the patient’s impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient’s medical record at the IRF.

In the unlikely event that the patient’s actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient’s medical record at the IRF.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be **completed within the first 4 days of the IRF admission**: it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient’s medical record at the IRF.

While CMS believes that it may be good practice to conduct the first interdisciplinary team meeting within the first 4 days of admission to develop the overall individualized plan of care, CMS believes that there may be other ways of developing the overall individualized plan of care. Thus, IRFs may develop this required documentation using whatever internal processes they believe are most appropriate.

*Medicare Benefit Policy Manual, Chapter 1, §110.1.3 - Required Individualized Overall Plan of Care. (Accessed May 4, 2017)*

**Intensive Level Rehabilitation:**

Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated (that is, CMS does not intend for this measure to be used as a “rule of thumb” for determining whether a particular IRF claim is reasonable and necessary).

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1 ½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule. Thus, *IRFs may also demonstrate a patient’s need for intensive rehabilitation therapy services* by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutive day period starting from the date of admission), as long as the reasons for the patient’s need for this program of intensive rehabilitation are well-documented in the patient’s IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than 3 hours of therapy per day or more than 15 hours of therapy per week, when all types of therapy
Interdisciplinary Team Approach:
Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient’s significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient’s significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals. At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

- A rehabilitation physician with specialized training and experience in rehabilitation services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient’s treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting. The periodic team conferences held a minimum of once per week. Medicare Benefit Policy Manual, Chapter 1, §110.2.5 - Interdisciplinary Team Approach to the Delivery of Care. (Accessed May 4, 2017)

Melodic Intonation Therapy: A technique used in language rehabilitation. Its purpose is to teach aphasic patients to produce useful phrases by intoning them in a melodic pattern with strong rhythmic support. Limited studies by a few institutions show some benefit for a small number of nonfluent aphasic patients otherwise unresponsive to conventional therapy. NCD for Melodic Intonation Therapy (170.2). (Accessed May 4, 2017)

Multiple Therapy Disciplines: A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care. For this reason, the information in the patient’s IRF medical record must document a reasonable expectation that, at the time of admission to the IRF, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy. Medicare Benefit Policy Manual, Chapter 1, §110.2.1 - Multiple Therapy Disciplines. (Accessed May 4, 2017)


Physician Supervision: A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive
rehabilitation therapy services. For this reason, the information in the patient’s IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient’s medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient’s care is demonstrated by documented face-to-face visits from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the patient’s IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient’s medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient’s capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than 3 days per week. However, the requirement for IRF physician supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress, in light of their medical conditions, by a rehabilitation physician with the necessary training and experience to make these assessments at least 3 times per week. The required rehabilitation physician visits must be documented in the patient’s medical record at the IRF. Medicare Benefit Policy Manual, Chapter 1, §110.2.4 - Physician Supervision. (Accessed May 4, 2017)

**Physical Therapy:** Services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. Medicare Benefit Policy Manual, Chapter 15, §230.1 - Practice of Physical Therapy. (Accessed May 4, 2017)

**Place of Residence:** Wherever the member makes his/her home. This may be his/her own dwelling, an apartment, a relative’s home, home for the aged, or some other type of institution. Medicare Benefit Policy Manual, Chapter 7, §30.1.2 - Patient’s Place of Residence. (Accessed May 4, 2017)

**Qualified Professional:** A physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician’s assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (see section 230.1 and 230.2) and may not supervise other therapy caregivers. Medicare Benefit Policy Manual, Chapter 15, §230 Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology. (Accessed May 4, 2017)

**Qualified Physical or Occupational Therapist:** A licensed physical or occupational therapist in the state where he/she is practicing. Medicare Benefit Policy Manual, Chapter 15, §230 - Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology. (Accessed May 4, 2017)

**Qualified Speech-Language Pathologist:** A qualified speech-language pathologist meets one of the following requirements:

- The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology or audiology) granted by the American Speech-Language Hearing Association; or
- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification. Medicare Benefit Policy Manual, Chapter 15.


III. REFERENCES

See above

IV. REVISION HISTORY

08/15/2017 Re-review with the following updates:

- Added the following note per the HPMS e-mail distribution dated August 11, 2017:
  
  CMS has determined that the National Coverage Determination requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2017 and 2018 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans.

- Added CPT code 93668

06/21/2017 Re-review; added Guideline 7 [Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)] (new to the policy); guideline based on the May 25, 2017 CMS Decision Memo for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CAG-00449N).

05/16/2017 Annual review with no updates.

04/19/2016 Annual review with the following update:
  Guideline # 8 (Examples of rehabilitation services that are not covered or with limited coverage, include but are not limited to) – Added “Home Health Physical Therapy” to list of LCDs that address diathermy treatment.

07/21/2015 Guideline 7.a ( Ultrasound, shortwave, and microwave diathermy treatments)

- Moved to Guideline 8.a
  Guideline 8.a (Diathermy Treatment)

- Guideline moved from Guideline 7.a; updated with the addition of the guideline from the retired Coverage Summary titled Diathermy Treatment

06/16/2015 Guideline 8.a [Sensory Integration Therapy (CPT Code 97533)] - Removed guideline; no longer included in the Prior Notification List.
04/21/2015  Annual review with the following update:
Guideline 7 (Comprehensive Computer-based Motion Analysis) - Changed default guideline for states with no LCDs from First Coast Services Options (MAC Part B) L29116 to UnitedHealthcare Medical Policy for Gait Analysis.

04/15/2014  Annual review; Guideline #6 (Passive Rehab Therapy for Mandibular Hypomobility) - Title of the default policy, i.e., UnitedHealthcare Medical Policy, changed from Mandibular Disorders to Temporomandibular Joint Disorders

02/18/2014  Additional updates to the Coverage Summary made to align with the Medicare Benefit Policy Manual updates in accordance with the Jimmo v. Sebelius Settlement Agreement; CMS Transmittal 179, January 14, 2014, Change Request 8458.


10/24/2013  Guideline #1 (Outpatient Rehabilitation Therapy) - Updated based on the Medicare Benefit Policy Manual Chapter 15, Section 220 Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance.

Guideline #2 (Inpatient Rehabilitation Services) - Deleted the following language under #2.a: Coverage stops when further progress toward the established rehabilitation goal is unlikely or when further progress can be achieved in a less intensive setting. Both the degree of improvement and the type of program needed to achieve further improvement must be considered.

04/29/2013  Annual review with the following updates:
- Added a note pertaining to the January 24, 2013 court approval of settlement agreement in the case of Jimmo v. Sebelius.
- Guidelines #6 (Complex Decongestive Physiotherapy) - Replaced the default guidelines for states with no LCDs from Trailblazer LCD for Complex Decongestive Physiotherapy (CDP) for Lymphedema (L26710) (retired) to Novitas LCD for Complex Decongestive Physiotherapy (CDP) for Lymphedema (L32698)

10/31/2012  Updated to include Guidelines #9 - Comprehensive Computer-based Motion Analysis.

04/23/2012  Annual review; Guidelines #2.b.1 (Comprehensive Outpatient Rehabilitation Facility/CORF) – added the sections, Required Services and Optional Services.

12/19/2011  Guidelines #6 (Complex Decongestive Physiotherapy/CDP) updated, i.e., deleted L18473 as guidelines reference for states with no LCDs as this LCD was retired.

04/26/2011  Annual review with the following updates:
- Guidelines #2.a.1 (Inpatient Rehabilitation Facility (IRF) Services) – updated to include information pertaining to preadmission screening and post-admission physician evaluation.
- Guidelines #2.b.1 (Comprehensive Outpatient Rehabilitation Facility/CORF) – updated to include a note pertaining to home evaluation visit.
- Guidelines #5 (Cognitive Therapy) – deleted the guidelines based on the TriSpan Local Article A36213 (retired); updated to include cognitive therapy coverage language based on the Medicare Benefit Policy Manual, Chapter 12, § 40.3
Occupational Therapy Services; also added references and links to the available LCDs.
- Guidelines #6 (Complex Decongestive Physiotherapy) – updated using the standard CS format.

08/24/2010 Note pertaining to therapy caps updated; the Medicare therapy caps does not apply to UnitedHealthcare MedicareComplete and UnitedHealthcare MedicareDirect plans.

V. ATTACHMENT(S)

**Attachment A - LCD Availability Grid**

**Comprehensive Computer-based Motion Analysis**
*(CPT codes 96000, 96001, 96002, 96003, 96004)*

CMS website accessed August 16, 2017

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