Rehabilitation Manual

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Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-3738
www.harmony-healthcare.com

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Introduction

About Harmony Healthcare International (HHI)

The mission of Harmony Healthcare International Inc. is to provide the post-acute care industry with the tools to obtain accurate and appropriate reimbursement, while ultimately providing better care to the residents. Through seminars, consulting and management services, Harmony educates, trains and advises providers with a user-friendly customer-first approach.

Kris has more than 24 years of experience in the Health Care industry with a specialty in the Long-Term and Post-Acute Care Arena. An Occupational Therapist degree from Tufts University followed by a Master's in Business Administration from Salem State University coupled with a Nursing Home Administrator's License affords Kris an in-depth perspective into the nursing home industry.

Initially providing direct care as an Occupational Therapist, Kris became familiar with the Medicare, Medicaid and HMO reimbursement systems. Her position evolved into the management of rehabilitation programs to Vice President of Operations for a national consulting company to Vice President of Reimbursement. Her experience includes the development and presentation of training modules (C.A.R.E.- Compliance, Audit, Analysis, Reimbursement and Regulatory an Efficiency) for independent owners to national organizations. Kris has owned and operated Harmony Healthcare international (HHI) for over 15 years. She proclaims that "Our on-site and off-site medical record review process is the platform for C.A.R.E. optimization and systems improvement."

Kris and her team of HealthCARE Specialists are integral players in Payment Reform with significant contributions to the policy process. The inordinate amount of regulatory change is nearly impossible to digest and implement in the required timeframes. This changing regulatory climate was a driving force in Harmony Healthcare International's (HHI) mission of to distill, synthesize and educate owners and caregivers which in turn facilitates high quality outcomes and optimal care.

Kris was appointed to and serves on the American Health Care Association (AHCA) Clinical Practice Committee (CPC). Kris is a nationally recognized speaker on SNF compliance and operational excellence in post-acute care.

1.800.530.4413
"We C.A.R.E. About Care"
www.harmony-healthcare.com

Introduction

Purpose of the Manual

The Harmony Healthcare Rehabilitation Manual (Volume II) is to be used as a tool for understanding the Rehabilitation Department as this entity relates to the Medicare Program. This manual contains guidelines, regulations and recommended systems for ensuring the appropriate coverage for Medicare beneficiaries. The goal of Harmony is to keep all participants informed of any changes in the Medicare system in order to enhance the overall Medicare decision-making process. If you would like a copy of this manual or if you have questions or suggestions, please contact:

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104
Topsfield, MA 01983
1.800.530.4413

Introduction

Scope of Services

Harmony Healthcare International provides consulting on in-house Rehabilitation Programs. Our regional staff is trained in the development and implementation of on-staff Occupational, Speech and Physical Therapy services. Our goal is to establish a facility integrated Rehabilitation approach allowing for improved patient care and employee satisfaction.

Our initial assessment outlines your facility specific operational and clinical needs including a one-year budget proposal.

Ongoing management services include:

- Implementation of operational requirements (staffing, equipment, etc.)
- Implementation of most effective treatment programs
- Establishment of quality assurance program
- Establishment of policy and procedures
- Monthly financial report inclusive of operational variances to budget, productivity, cost per hour, profitability and more.
- Management of on-staff clinicians to enhance employee practice patterns, care plans, interdisciplinary treatment and development of new rehabilitation programs.
- Assist with community awareness and marketing calls in support of facility marketing strategy.
- Establishment of systems for weekly rehabilitation meetings, care plan attendance, and other facility requested requirements.
- Assist facility with Denials Management Program.
- Mentoring, directing and supporting rehabilitation department.

Rehabilitation Training Modules

- Restraint Reduction
- Body Mechanics
- Transfer Training
- Restorative Feeding

Rehabilitation Training Modules (Continued)

- Range of Motion
- ADL Training
- Adaptive Equipment
- Functional Maintenance
- Contracture Prevention
- Dysphagia
- Dementia Management
- Aphasia
- Restorative Nursing
- Skilled Documentation

Personnel

Director of Rehabilitation/Team Leader

Organization Relationships

1. Reports to Facility Administrator

2. Supervises staff Therapists, Therapy Assistants, and Therapy Aides.

3. Coordinates with therapy contractors, other department heads, and participates in facility meetings.

Responsibilities

1. Coordinates the operations of the rehab department to meet resident needs, the Facility's fiscal requirements and federal and state regulations.

2. Coordinates the assignment of residents and other responsibilities to staff therapists and therapy contractors in an appropriate manner.

3. Screens, evaluates, and treats residents. Assures that residents admitted for treatment receive required therapy services and service delivery is documented appropriately.

4. Orients, trains, and counsels rehab department employees to achieve and maintain a high standard of care.

5. Assists the facility Administrator in the hiring and terminating of department employees according to facility protocol, policy and procedure.

6. Assures compliance with appropriate policies and procedures for the department and facility.

7. Develops and maintains a medical records system that:
   a. Is accurate and concise.
   b. Meets governmental and third-party payer requirements.
   c. Reflects a clear picture of the resident's problems, the therapist's intervention, and the resident's outcome.

8. Develops and maintains an administrative record system that provides an accurate record of staff productivity.

9. Communicates and coordinates the rehab department functions with other departments in a constructive manner that helps build team rapport and effectiveness.

10. Communicates with Administrator regarding department programs, goals, objectiveness, problems, and successes.

11. Communicates with the physicians regarding resident problems, progress, and department programs.

12. Communicates to the public and to medical personnel outside the facility regarding the therapy services as directed by facility administrator.

13. Participates in:
    a. Community awareness activities.
    b. Facility in-service training programs.
    c. Resident care conferences.
    d. Weekly rehabilitation meetings.
    e. Marketing.
    f. Departmental head meetings.
    g. Inquiry/admission process.
    h. Facility quality assurance meetings.

14. Develops department revenue and controls expenditure of funds to meet budgetary requirements.

15. Set goals and objectives for the department and implements activities to accomplish them.

16. Supervises therapy student programs.

Qualifications

1. Graduate from an accredited program for Physical Therapy, Occupational Therapy, or Speech-Language Pathology with a Certificate of Clinical Competency.

2. Current licensure as a therapist in the state of practice.

3. Management and supervisory skills.

4. Must be able to communicate in English both verbally and in writing.

5. Must possess problem-solving skills of the type and at a level necessary to accomplish the job.

6. Must possess excellent communication skills and can relate professionally and positively to residents, resident's family members, and facility staff.

7. Must be capable of maintaining regular attendance.

8. Must meet all local health regulations, pass post-offer drug test if required, and pass post-employment physical exam if required.

9. Must be capable of performing the Responsibilities of this job, with or without reasonable accommodation.

Interpersonal Skills

Demonstrate active listening techniques; gains support through effective relationships; treats others with dignity and respect; seeks feedback; set clear standards for performance; evaluates job performance and provides effective feedback; establishes systems to measure effectiveness, efficiency, and service; creates and maintains reporting mechanisms.

Continuing Education

Attends in-service and education programs; attends continuing education required for maintenance of professional certification or licensure.

Physical Demands

The physical demands described here represent those that must be met by an employee to successfully perform the essential functions of this job. While performing the duties of this job, the employee is frequently required to stand and walk. The employee is occasionally required to sit; use hands to finger, handle, or feel; reach with hands and arms; and talk and to hear. Light to moderate travel to other sites may be required. Occasional physical effort with medium to heavy objects. Transferring patients weighing between 100 to 250 lbs is occasionally required. Specific vision abilities required by this job include close vision, distance vision, and peripheral vision.

Work Environment

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. While performing the duties of this job, the employee may be exposed to blood or other body fluids, fumes or airborne particles and toxic or caustic chemicals. The noise level in the work environment is usually moderate.

Job Description Review

I understand this job description, its requirements, and that I am expected to complete all duties as assigned. I understand the job duties may be altered from time to time. I have noted below any accommodations that are required to enable me to perform these duties. I have also noted below any job duties that I am unable to perform, with or without accommodation.

Employee's Signature & Date

Supervisor's Signature & Date

cc: Personnel File
Employee

Occupational Therapist

Qualifications

1. Reports to Director of Occupational Therapy or Director of Rehabilitation.
2. Supervises staff Occupational Therapy Assistants, and Occupational Therapy Aides.
3. Coordinates with other staff, other department heads, and participates in facility meetings.

Responsibilities

1. Screens, evaluates and treats residents.
2. Evaluate resident within two working days of physician referral.
3. Develop effective treatment plans.
4. Supervise Occupational Therapy Assistants and Rehab Aides in direct resident care and resident related activities in accordance with state practice acts.
5. Treat residents according to a treatment plan approved by the attending physician.
6. Communicate with supervisor and other health team members regarding resident progress, problems, and plans.
7. Participate as necessary in resident care conferences and weekly rehabilitation meetings.
8. Participate in in-service training programs.
9. Record clinical documentation according to accepted regulatory, facility, and professional guidelines.
10. Record daily treatments and labor per facility procedures.
11. Establish and instruct caregivers in resident specific maintenance programs.
12. Participate in discharge planning.

13. Secure necessary durable medical equipment and adaptive equipment for residents to facilitate independence.

14. Act as a clinical preceptor for affiliating Occupational Therapy or Occupational Therapy Assistant schools.

15. Comply with state regulations and national standards as they apply to the practice of Occupational Therapy.

Qualifications

1. Graduate from an American Occupational Therapy Association accredited School of Occupational Therapy.

2. Current licensure as an Occupational Therapist in the state of current practice.

3. Must be able to communicate in English, both verbally and in writing.

4. Must possess problem-solving skills of the type and at a level necessary to accomplish the job.

5. Must possess good communication skills and be able to relate professionally and positively to residents, resident's family members, and facility staff.

6. Must meet all local health regulations, pass post-offer drug test (if required), and pass post-employment physical exam if required.

7. Must be capable of performing the responsibilities of this job, with or without reasonable accommodations.

8. Must meet physical and sensory requirements (with or without the aid of mechanical devices): Mobility (includes walking, good balance), reaching, bending, lifting, grasping, fine hand coordination, ability to see and hear, ability to read and write, ability to communicate with residents, family members, personnel, and ability to remain calm under stress.

Interpersonal Skills

Demonstrate active listening techniques; gains support through effective relationships; treats others with dignity and respect; seeks feedback.

Continuing Education

Attends in-service and education programs; attends continuing education required for maintenance of professional certification or licensure.

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Employee's Signature and Date

Supervisor's Signature and Date

cc: Personnel File
Employee

Certified Occupational Therapy Assistant

Organizational Relationships

1. Reports to the Director of Rehab, the Director of Occupational Therapy, and Staff Occupational Therapist.

Responsibilities

1. Treats residents as directed by the Occupational Therapist.
2. Records treatments given in medical record.
3. Participates in resident care conferences and weekly rehabilitation meetings.
4. Assists with cleaning and maintenance of treatment area and department.
5. Communicates with supervisor and other interdisciplinary team members regarding resident progress, problems, and plans.
6. Participates in facility in-service training programs.
7. Records daily treatments and labor according to facility procedure.
8. Instructs families and staff in maintenance or home exercise programs as directed by the Occupational Therapist.

Qualifications

1. Graduate from an American Occupational Therapy Association Accredited School of Occupational Therapy.
2. Current license in practicing state, if state licenses Occupational Therapy Assistants.
3. Must be able to communicate in English, both verbally and in writing.
4. Must possess good communication skills and be able to relate professionally and positively to residents, resident's family members, and facility staff.

5. Must meet all local health regulations, pass post-offer drug test if required, and pass post-employment physical exam if required.

6. Must be capable of performing the responsibilities of this job, with or without reasonable accommodation.

7. Must meet physical and sensory requirements (with or without the aid of mechanical devices). Mobility (includes walking, good balance), reaching, bending, lifting, grasping, fine hand coordination, ability to see and hear, ability to read and write, ability to communicate with residents, family members, personnel, and ability to remain calm under stress.

Interpersonal Skills

Demonstrate active listening techniques; gains support through effective relationships; treats others with dignity and respect; seeks feedback.

Continuing Education

Attends in-service and education programs; attends continuing education required for maintenance of professional certification or licensure.

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_____

Employee's Signature & Date

_____

Supervisor's Signature & Date

cc: Personnel File
Employee

Physical Therapist

Organizational Relationships

1. Reports to Director of Physical Therapy or Director of Rehabilitation.

2. Supervises Physical Therapy Assistants, and Physical Therapy Aides.

Responsibilities

1. Screens, evaluates, and treats residents.

2. Evaluates resident within two working days of physician referral.

3. Develops effective treatment plans.

4. Supervises Physical Therapist Assistants and Physical Therapy Aides in direct resident care and resident related activities in accordance with state practice acts.

5. Treats residents according to a treatment plan approved by the attending physician.

6. Communicates with supervisor and other health team members regarding resident progress, problems, and plans.

7. Participates as necessary in resident care conferences and weekly rehabilitation meetings.

8. Participates in in-service training programs.

9. Records clinical documentation according to accepted regulatory, corporate, and professional guidelines.

10. Records daily treatments and labor per corporate procedures.

11. Establishes and instructs caregivers in resident specific maintenance programs.

12. Participates in discharge planning.

13. Secures necessary durable medical equipment and adaptive equipment for residents to facilitate independence.

14. Acts as a clinical preceptor for affiliating Physical Therapy or Physical Therapy Assistant schools.

15. Complies with state regulations and national standards as they apply to the practice of Physical Therapy.

Qualifications

1. Graduate from an American Physical Therapy Association Accredited School of Physical Therapy.

2. Current licensure as a Physical Therapist in the state of current practice.

3. Must be able to communicate in English, both verbally and in writing.

4. Must possess problem-solving skills of the type and at a level necessary to accomplish the job.

5. Must possess good communication skills and be able to relate professionally and positively to resident's family members and facility staff.

6. Must meet all local health regulations, pass post-offer drug test if required and pass post-employment physical exam if required.

7. Must be capable of performing the responsibilities of this job, with or without reasonable accommodation.

8. Must meet physical and sensory requirements (with or without the aid of mechanical devices). Mobility (includes walking, good balance), reaching, bending, lifting, grasping, fine hand coordination, ability to see and hear, ability to read and write, ability to communicate with residents, family members, personnel, and ability to remain calm under stress.

Interpersonal Skills

Demonstrate active listening techniques; gains support through effective relationships; treats others with dignity and respect; seeks feedback.

Continuing Education

Attends in-service and education programs; attends continuing education required for maintenance of professional certification or licensure.

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_____

Employee's Signature & Date

_____

Supervisor's Signature & Date

cc: Personnel File
Employee

Physical Therapy Assistant

Organization Relationships

1. Reports to the Director of Rehabilitation, the Director of Physical Therapy, and Staff Physical Therapist.

Responsibilities

1. Treats residents as directed by the Physical Therapist.

2. Records treatments given in medical record.

3. Participates in resident care conferences and weekly rehabilitation meetings.

4. Assists with cleaning and maintenance of treatment area and department.

5. Communicates with supervisor and other interdisciplinary team members regarding resident progress, problems, and plans.

6. Participates in facility in-service training programs.

7. Records daily treatments and labor according to facility procedure.

8. Instructs families and staff in maintenance programs as directed by the Physical Therapist.

9. Protects resident and associates by adhering to infection control policies and protocols. Maintains safe and clean working environment by complying with facility and departmental procedure rules and regulations.

Qualifications

1. Graduate from an accredited Physical Therapy Assistant program.

2. Current license in practicing state, if state licenses Physical Therapy Assistants.

3. Must meet physical and sensory requirements (with or without the aid of mechanical devices). Mobility (includes walking, good balance), reaching, bending, lifting, grasping, fine hand coordination, ability to see and hear, ability to read and write, ability to communicate with residents, family members, personnel, and ability to remain calm under stress.

Interpersonal Skills

Demonstrate active listening techniques; gains support through effective relationships; treats others with dignity and respect; seeks feedback.

Continuing Education

Attends in-service and education programs; attends continuing education required for maintenance of professional certification or licensure.

Physical Demands

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_____

Employee's Signature & Date

_____

Supervisor's Signature & Date

cc: Personnel File
Employee

Speech-Language Pathologist

Organizational Relationships

1. Reports to Director of Speech-Language Pathology or Director of Rehabilitation

Responsibilities

1. Screens, evaluates, and treats residents.
2. Evaluates resident within two working days of physician referral.
3. Develops effective treatment plans.
4. Treats residents according to a treatment plan approved by the attending physician.
5. Communicates with supervisor and other health team members regarding resident progress, problems, and plans.
6. Participates as necessary in resident care conferences and weekly rehabilitation meetings.
7. Participates in in-service training programs.
8. Records clinical documentation according to accepted regulatory, facility, and professional guidelines.
9. Records daily treatments and labor per facility, procedures.
10. Establishes and instructs caregivers in resident specific maintenance programs.
11. Participates in discharge planning.
12. Secures necessary durable medical equipment and adaptive equipment for residents to facilitate independence.
13. Acts as a clinical preceptor for affiliating Speech Therapy schools.
14. Complies with state regulations and national standards as they apply to the practice of Speech-Language Pathology.

Qualifications

1. Certificate of Clinical Competence from the American Speech, Language, and Hearing Association.

2. A Speech-Language Pathologist in the Clinical Fellowship Year (CFY) with appropriate supervision from a certified and licensed S.L.P.

3. Current state license as an S.L.P. in the state of practice.

4. Must meet physical and sensory requirements (with or without the aid of mechanical devices). Mobility (includes walking, good balance), reaching, bending, lifting, grasping, fine hand coordination, ability to see and hear, ability to read and write, ability to communicate with residents, family members, personnel, and ability to remain calm under stress.

Interpersonal Skills

Demonstrate active listening techniques; gains support through effective relationships; treats others with dignity and respect; seeks feedback.

Continuing Education

Attends in-service and education programs; attends continuing education required for maintenance of professional certification or licensure.

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_____

Employee's Signature & Date

_____

Supervisor's Signature & Date

cc: Personnel File
Employee

Rehabilitation Aide

Organizational Relationships

1. Reports to the Director of Rehabilitation and to licensed staff therapists.
2. May report to Therapy Assistant(s) where state regulations allow.

Responsibilities

1. Transport residents as scheduled to and from treatment area.
2. Prepare residents for treatment and set up equipment in treatment area.
3. Assist with treatment under direct supervision of licensed Therapist.
4. Assist in maintaining the cleanliness of the treatment area and department.
5. Assist with maintaining an adequate stock of supplies and equipment.
6. Participate in department meetings and in facility meetings.
7. Perform assigned clerical duties.

Qualifications

1. High school diploma.
2. Training as a Therapy Aide and completion of on the job orientation.
3. Must speak and understand English.
4. Good physical and mental health.
5. Must be able to relate positively to residents, resident's family members, and facility staff.
6. Must meet all local health regulations, pass post-offer drug test if required, and pass post-employment physical exam if required.
7. Must be capable of performing the responsibilities of this job, with or without reasonable accommodation.

8. Must meet physical and sensory requirements (with or without the aid of mechanical devices. Mobility (includes walking, good balance), reaching, bending, lifting, grasping, fine hand coordination, ability to see and hear, ability to read and write, ability to communicate with residents, family members, personnel, and ability to remain calm under stress.

Interpersonal Skills

Demonstrate active listening techniques; gains support through effective relationships; treats others with dignity and respect; seeks feedback.

Continuing Education

Attends in-service and education programs; attends continuing education required for maintenance of professional certification or licensure.

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_____

Employee's Signature & Date

_____

Supervisor's Signature & Date

cc: Personnel File
Employee

Personnel

Credentials

Policy

All members of the therapy department, whether contract or staff, shall possess the basic education and training credentials as required by the appropriate national professional organizations, state licensure boards, and/or corporate requirements.

Procedures

1. Display current therapist's credentials listed below:

    a. Current state license
    b. ASHA Certificate of Clinical Competence (CCC) (Speech only)

2. Maintain the current copies of the therapist's credentials in the employee file.

Personnel

Clinical Supervision

Policy

Clinical supervision will be provided for staff, contract personnel and students on an ongoing basis to achieve and maintain the quality of resident care.

Definitions

- Direct Supervision – The designated supervisor is on the premises and is quickly and easily available if needed. Refer to current CMS guidelines related to direct versus indirect supervision for Medicare patients.
- Indirect Supervision – The designated supervisor may or may not be on the premises, provides either written or oral instructions for resident treatment, and is easily available if needed.

Scope

Assistants

1. Direct supervision of P.T.A.'s or C.O.T.A.'s will be in compliance with discipline specific state and/or national regulations.

2. Indirect supervision of the P.T. Assistants or C.O.T.A.'s must occur as needed to provide quality resident care.

Speech-Language Pathologists in their Clinical Fellowship Year (CFY)

1. Direct and indirect supervision during the CFY will be in compliance with state and/or national regulations.

Therapy Aides

1. Direct supervision of all therapy aides (P.T., O.T.) must be provided from the appropriate therapist when the aide is involved in resident-related tasks.

2. Direct supervision of therapy aides by therapy assistants will be according to the State Practice Acts for the specific discipline.

Therapy Students

1. Students in physical therapy, occupational therapy or speech-language pathology educational programs should receive 100% direct supervision from the clinical field supervisor.

Employee Orientation

Policy

All new employees will take part in the standard facility orientation program. The Director of Rehabilitation will be responsible for orienting the new employees to their particular work area.

Procedure

1. The Director of Rehabilitation is to send new employees to the facility designated trainer at the specified orientation time.

2. The facility-designated trainer is to orient the employee and complete the Orientation Checklist.

3. The checklist is to be signed by the employee, Administrator, department head and the facility designated trainer and filed in the employee's personnel file.

4. The Rehabilitation Department Head is to:

    a. Orient the new employee to therapy treatment areas, storage, equipment locations and equipment usage.

    b. Review the location and content of the Rehabilitation Policy and Procedure Manual.

    c. Review the facility's Policies and Procedures for Resident's Rights, Employee and Resident Safety, Fire, and Disaster Preparedness.

    d. Review facility organizational chart.

    e. Provide the employee with a copy of his/her job description, which includes reporting relationships, duties, responsibilities and practice guidelines.

    f. Explain department policies regarding vacation, sick leave, medical leave, and personal leave.

    g. Implement Physical, Occupational Therapy and Speech-Language Pathology orientation as outlined in the Rehabilitation Policy and Procedure Manual.

    h. Review the facility employee orientation checklist to assure that the orientation process has been completed.

Personnel

Rehabilitation Department Orientation Checklist

Policy

All staff shall be oriented to the Rehabilitation Department within one week of their starting date.

Procedure

The following activities shall be scheduled for all personnel who join the Rehabilitation Department Staff. Unlicensed personnel will be oriented only to those areas applicable to their job description. Those teaching the activity should initial this form as the section is completed.

		Initial
I.	**Staff Introductions**	
A.	Rehabilitation staff	_____
B.	Facility staff	_____
II.	**Compliance**	
A.	Code of Ethics	_____
B.	Non-retaliation	_____
III.	**Facility Physical Plant**	
A.	Facility tour/orientation	_____
B.	Rehabilitation Department tour/orientation	_____
1.	Emergency equipment	_____
2.	Gym equipment	_____
3.	Linens	_____
4.	Gait equipment	_____
5.	Weights	_____
6.	Mat tables	_____
7.	Hydro area/equipment	_____
8.	Office supplies/equipment	_____
9.	Medical record forms	_____
10.	Administrative forms	_____
11.	Personal Equipment closet	_____

Initial

12. Schedule board _____
13. Work station _____
14. Modality equipment _____
15. Testing supplies/equipment _____
16. Treatment supplies/equipment _____
17. Computer system training _____

IV. Organization

A. Company/facility organization _____
B. Rehabilitation Department _____

1. Organization chart _____
2. Job descriptions _____
3. Supervisor/staff relationships _____
4. Role relationships (facility/Rehabilitation Services Department) _

V. Policies and Procedures: Administrative

A. Staff schedules

1. Hours _____
2. Master schedule development _____
3. Requests for time off _____

B. Payroll sheets (time cards) _____
C. Sick days/absenteeism _____
D. Dress code _____
E. Telephone/cell phone usage _____
F. Continuing education _____
H. Safety _____

1. Incident reports _____
2. Emergency _____
3. General Rehabilitation safety policies _____

I. Meetings

1. Departmental _____
2. Facility _____

Initial

J. Staff Evaluations _____
K. Quality Assurance _____
L. Student Programs _____

VI. Policy and Procedures: Resident related

A. Resident referral

1. Physician orders _____
2. Scheduling _____

B. Documentation

1. Rehabilitation forms _____
2. Productivity documentation or other facility specific data collection forms _____

C. Resident charge system

1. Resident pay types _____

a. Medicare _____
b. Medicaid _____
c. Private _____
d. Veterans Administration _____
e. Other _____

2. Ancillaries _____
3. Therapy Services or billing Log _____

D. Weekly Rehabilitation Meetings/Weekly Beneficiary Review Meeting _____
E. Restorative Nursing Program _____
F. Confidentiality _____
G. Care planning _____

VII. Special Procedures

A. Discipline specific protocols _____
B. Ordering supplies, equipment, vendor information _____

Initial

VIII. Completion of the following:

A. Payroll system _____
B. Copy of state license _____
C. Copy of Driver license/Social Security card _____
D. Office key _____
E. Address and telephone number in department records _____
F. Facility general orientation _____
G. Desk assignment _____
H. Reading and signing of policies and procedures manual _____
I. Confidentiality statement _____

IX. General orientation to all services:

A. Physical Therapy _____
B. Occupational Therapy _____
C. Speech/Language Pathology _____
D. Social Services _____
E. Nursing _____

X. Compliance

A. Provide Copy/Review Code of Ethics (Facility Specific) _____
B. Provide Copy/Review Compliance Policy (Facility Specific) _____
C. Provide Copy/Review Current Medicare Benefit Policy Manual (Chapters 8 and 15) _____
D. Provide Copy/Review discipline specific local Medicare Coverage determination (LCD) _____
E. Provide Copy/Review Policy for reporting Medicare Fraud (Facility-Specific) _____
F. Introduction to Facility Compliance Officer _____

The scheduled orientation activities have been successfully completed on: _____

_____
Employee Signature Date

_____
Director Signature Date

State Practices Act

Introduction

The practice act is a statute which defines the **scope and practice** of therapy and nursing within the jurisdiction, outlines **licensing requirements** for nurses and establishes penalties for violations of the law.

Each state has the ability to enact its own practice act. As a result, **variations exist between states**. In an effort to limit the variations, the Federation of State Boards has developed a model definition. Since the practice act, along with the accompanying rules constitutes the law governing therapy practice within a state, it is of utmost importance that the practice act be readily available for therapists/staff to easily access.

An annual review of state practice acts with staff is strongly recommended to ensure that the therapists and nurses are aware of the rules and regulations outlined in the act, in addition to any updates.

Refer to **State Practice Acts listed by State.**

State Practices Act

State	PT	OT	SLP	Nursing
Alabama	Click Here	Click Here	Click Here	Click Here
Alaska	Click Here	Click Here	Click Here	Click Here
Arizona	Click Here	Click Here	Click Here	Click Here
Arkansas	Click Here	Click Here	Click Here	Click Here
California	Click Here	Click Here	Click Here	Click Here
Colorado	Click Here	Click Here	Click Here	Click Here
Connecticut	Click Here	Click Here	Click Here	Click Here
Delaware	Click Here	Click Here	Click Here	Click Here
District of Columbia	Click Here	Click Here	Click Here	Click Here
Florida	Click Here	Click Here	Click Here	Click Here
Georgia	Click Here	Click Here	Click Here	Click Here
Hawaii	Click Here	Click Here	Click Here	Click Here
Idaho	Click Here	Click Here	Click Here	Click Here
Illinois	Click Here	Click Here	Click Here	Click Here
Indiana	Click Here	Click Here	Click Here	Click Here
Iowa	Click Here	Click Here	Click Here	Click Here
Kansas	Click Here	Click Here	Click Here	Click Here
Kentucky	Click Here	Click Here	Click Here	Click Here
Louisiana	Click Here	Click Here	Click Here	Click Here
Maine	Click Here	Click Here	Click Here	Click Here
Maryland	Click Here	Click Here	Click Here	Click Here
Massachusetts	Click Here	Click Here	Click Here	Click Here
Michigan	Click Here	Click Here	Click Here	Click Here
Minnesota	Click Here	Click Here	Click Here	Click Here
Mississippi	Click Here	Click Here	Click Here	Click Here
Missouri	Click Here	Click Here	Click Here	Click Here
Montana	Click Here	Click Here	Click Here	Click Here
Nebraska	Click Here	Click Here	Click Here	Click Here
Nevada	Click Here	Click Here	Click Here	Click Here
New Hampshire	Click Here	Click Here	Click Here	Click Here
New Jersey	Click Here	Click Here	Click Here	Click Here
New Mexico	Click Here	Click Here	Click Here	Click Here
New York	Click Here	Click Here	Click Here	Click Here
North Carolina	Click Here	Click Here	Click Here	Click Here
North Dakota	Click Here	Click Here	Click Here	Click Here
Ohio	Click Here	Click Here	Click Here	Click Here
Oklahoma	Click Here	Click Here	Click Here	Click Here

State Practices Act

Oregon	Click Here	Click Here	Click Here	Click Here
Pennsylvania	Click Here	Click Here	Click Here	Click Here
Rhode Island	Click Here	Click Here	Click Here	Click Here
South Carolina	Click Here	Click Here	Click Here	Click Here
South Dakota	Click Here	Click Here	Click Here	Click Here
Tennessee	Click Here	Click Here	Click Here	Click Here
Texas	Click Here	Click Here	Click Here	Click Here
Utah	Click Here	Click Here	Click Here	Click Here
Vermont	Click Here	Click Here	Click Here	Click Here
Virginia	Click Here	Click Here	Click Here	Click Here
Washington	Click Here	Click Here	Click Here	Click Here
West Virginia	Click Here	Click Here	Click Here	Click Here
Wisconsin	Click Here	Click Here	Click Here	Click Here
Wyoming	Click Here	Click Here	Click Here	Click Here

Committee Meetings

Policy

To improve communication between Rehabilitation Services and the facility, it is essential that each therapy service share information at specific committee meetings.

This information should be given to the Committee Coordinator prior to its commencement if the therapist is unable to attend.

The following committee meetings may be required, as appropriate.

Admissions

- Weekly Rehabilitation Meeting
- Resident Care Planning Conference
- Department Head Meeting
- Medicare Meeting
- Resident Care Policy Review
- Quality Assurance and Assessment
- Morning Meeting

Procedure

1. Obtain the dates and times of these meetings from the Administrator.
2. Arrange staffing schedule to allow participation in appropriate meetings.

Meetings

Admissions Meeting

Purpose

To provide coordinated interdisciplinary communication regarding resident inquiries, admissions, discharges and room transfers.

Frequency

As appropriate.

Members

Administrator, Director of Nursing, Admissions Coordinator, Director of Rehabilitation, Medical Records and appropriate Department Heads.

Items Discussed

- Inquiries pending, level of care/payor status
- New Admissions
- Discharges
- Room transfers
- Resident's change of condition
- Special programs/activities for the day

Meetings

Rehabilitation Conference

Purpose

To provide an opportunity for interdisciplinary team members to discuss resident's plan of treatment.

Frequency

Weekly

Members

Administrator, Director of Nursing, Rehab Manager, Physiatrist, Charge Nurse, Restorative Nursing Assistant, Physical Therapist, Occupational Therapist, Speech Language Pathologist, Social Services, and Discharge Planner. Dietary Services and Certified Nurse Assistants should attend as appropriate.

Items Discussed

- Interdisciplinary goals
- Resident's progress
- Equipment needs
- Discharge planning
- Family teaching
- Facility denial letters

Meeting format may include, but is not limited to:

- Review of previous week's minutes

- Review of all new admits since last meeting
- Discussion of all residents receiving skilled therapy services
- Report from nursing personnel regarding residents with identified changes in condition
- Presentation of additional residents as appropriate

Family members/significant others/residents may attend the rehabilitation conference as appropriate.

Minutes will be maintained in a notebook in the Rehabilitation Department.

Meetings

Resident Care Planning Conference

Purpose

To provide the highest quality of care planning through use of a coordinated interdisciplinary approach.

Frequency

Twice weekly or as needed per facility census.

Members

Director of Nursing, Dietary Supervisor, Social Services Coordinator, Activities Coordinator, Physical Therapist, Occupational Therapist, Speech Language Pathologist. May include Respiratory Therapist, Restorative Nursing Assistant and Certified Nurse Assistant staff.

Items Discussed

- Interdisciplinary problems, goals, and treatment approaches are discussed and listed on the resident care plan
- New Admissions are discussed within seven days of admission
- Residents are discussed with updates and deletions recorded at least quarterly
- Appropriateness of care plan entries
- Changes in condition

Meetings

Department Head Meeting

Purpose

To facilitate open communication and sharing of information between key personnel. Each Department Head is responsible to share appropriate information with his/her staff.

Frequency

Scheduled as needed by the Administrator; may be weekly or daily.

Members

Administrator, Director of Nursing, Rehabilitation Services, Dietary, Social Services, Activities, Housekeeping/Laundry, Maintenance.

New Admissions are discussed

Items Discussed

- Department update
- Changes in policies and procedures
- Facility updates
- Department head and consultant schedules
- Community education
- Community awareness

Medicare Meeting Signature Page

Overview

On a weekly basis, the Medicare team discusses the coverage criteria for each Medicare Part A beneficiary along with an administrative review of the timely completion of MDS assessments, denial letters, certification forms, consent forms, Medicare secondary payer letters and beneficiary voluntary placement letters.

All participants sign for attendance at each weekly Beneficiary Review Meeting.

Meetings

Beneficiary Review Signature Page

Facility: _____

Date: _____

Attendees Signatures

Administrator: _____

Director of Nursing: _____

MDS Coordinator: _____

Social Services: _____

Admissions: _____

Restorative Nurse Aide: _____

Business Office: _____

Therapy Representative: _____

Charge Nurse: _____

Charge Nurse: _____

Respiratory: _____

Other: _____

Resident Care Policy Review

Purpose

To review and revise Resident Care Policy Manuals.

Frequency

At least yearly, usually prior to survey. It may be scheduled more frequently, as needed.

Members

Administrator, Medical Director, Director of Nursing, Pharmacist, Rehabilitation Services, Social Services, Activities, Dietary, Housekeeping/Laundry, Maintenance.

Items Discussed

- Review policies and procedures for accuracy
- Delete non-existent policies
- Update and revise appropriate policies
- Include new policies and procedures, as appropriate

Meetings

Quality Assurance and Assessment

Purpose

To provide a systematic and ongoing self-evaluation process geared toward identifying and resolving problems, targeting areas for program improvement and development, and enhancement of overall resident care and quality of life.

Frequency

Quarterly, may be more often at facility discretion.

Members

Administrator, Medical Director, Director of Nurses, and at least three other staff members from various departments such as social service, activities, dietary, rehabilitation, housekeeping, etc.,

Items Discussed

- Identification of areas to be studied
- Format for data collection and communication of findings
- Establishment of continuous Quality Improvement studies including time frames, responsibilities, data collection, tools, and reporting mechanisms

Therapy Timesheet

Key Points

1. The Therapy Time Sheet is used for payroll purposes.

2. A Time Sheet must be completed for each pay period.

3. Each therapist is assigned a "home base" for payroll purposes.

4. At the end of each pay period, the time sheet must be given to the office manager/bookkeeper at your facility.

Instructions

1. Write in your name, employee number, and month/year.

2. Circle your therapy discipline.

3. Write in the name(s) of the facility/facilities for which you are providing coverage. The first block is used for your home base facility.

4. Write in the date for each day you worked.

5. Write in your "time-in" and "time-out" under the appropriate facility. Drive time between facilities is billed to the facility that you are traveling to. Therefore, your actual "time in" to the facility you are traveling to will be the time you left the previous facility. For example, you left Facility A at 10:30 and arrived at Facility B at 11:00. Your "time-in" at Facility B would be written as 10:30.

6. Using your "time-in" and "time out", total your hours and write them in under the "hours worked" column.

7. For each day, write your total house in the "total" column in the far-right hand column.

8. At the end of the pay period, total your hours for each facility and write the total in the "total" column at the bottom of the time sheet.

9. Sign the time sheet and obtain a signature from your home base Administrator or a designated facility representative.

Therapy Timesheet

Name of Employee: _____ PT / OT / SLP

Facility: _____

		Lunch			Business Office Will Tabulate	
Date	Time In	Time Out	Time In	Time Out	Total Hours	Signature

Approved by: _____

Monthly Productivity - Therapists

Instructions

1. This tool is to be used to monitor daily activity within the facility.

2. Complete this tool each day you are in the facility.

3. Write your facility name, the date and your name at the top of the sheet in the designated areas.

4. For each date indicate the number of minutes in each box spent on each task.

5. The sheet is divided in direct and indirect time. Complete both sections for each date.

6. Add up total minutes for the day divide that number by 60 and fill in the total hours in the building box for the associated date.

7. Total the minutes provided for each patient then divide that number by 60 and enter the total billed hours in the associated box for that date.

8. For each date divide the total billed hours number by the total hours in building to determine daily productivity.

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Productivity Tracking

Monthly Productivity – Therapists

Facility/Client Name:_____ #_____ For the Month/Year of _____ / _____ Therapist Name: _____

PT/PTA/OT/COTA/SLP

		Time = Total Direct Minutes to Patient																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Indirect Time:	Patient Screens																															
	Nursing/Admin. Meeting																															
	In-services																															
	Aide Supervision																															
	Staff Clinical Supervision																															
	Staff Scheduling/Billing																															
	Documentation																															
	Wheelchair Management																															
	Family Interactions																															
Total Indirect Hours																																
Patients:																																
Total Billed Hours																																
Total Hours in Building																																
Productivity																																

CPT = Indicate Minutes per CPT Code

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www.harmony-healthcare.com

Department Productivity– Weekly

1. This tool will be used by each Rehab Department head to monitor discipline productivity on a weekly basis.

2. Record each therapist's name in the appropropriate discipline section.

3. For each therapist indicate title (OT, COTA, PT, PTA).

4. Record the total billable hours and total hours in the building for the entire week.

5. Calculate the total billable minutes by multiplying the total billable hours for each therapist by 60. Enter the total billable minutes in the associated column.

6. Calculate total minutes by multiplying total hours by 60.

7. Determine productivity by dividing total billable minutes by total minutes.

Productivity Tracking

Productivity

Month: _____ Week: _____ Date: _____

Existing Staff	Discipline	Total Billable Hours	Total Hours	Total Billable Minutes	Total Minutes	Productivity
PT						
Total PT						
OT						
Total OT						
ST						
Total ST						
TOTAL						
Without Rehab Director						

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www.harmony-healthcare.com

Productivity Tracking

Productivity Sign-In Sheet

Instructions

1. This tool will be used by the Rehab Manager and Administrator to monitor productivity on a weekly basis.

2. For each day you are in the facility, you will complete this tool.

3. Write the date, your name, the time you got to the facility, and the time you left the facility.

4. Convert your total time in the facility into minutes and put in the Time in Facility Minutes column.

5. Total all patient care minutes provided (excluding Part A evaluation minutes) and enter the minutes in the Patient Care Minutes column.

6. This form must be faxed to Harmony Healthcare at the end of each treatment week. The last therapist in the facility at end of week [or designated individual] is responsible for faxing to the Harmony Corporate office at 978-887-3738.

Productivity Tracking

Sign-In Sheet / Productivity Form

Discipline: Physical Therapy

Facility: _____

Month: _____

Date	Name	Title	Time In	Time Out	Total Time In Facility (Minutes)	Patient Care Minutes	Productivity	Signature
11/1/14	Patty PT	RPT	8:00	4:00	A	B	A/B	Patty PT

Productivity Tracking

Sign-In Sheet / Productivity Form

Discipline: Occupational Therapy

Facility: _____

Month: _____

Date	Name	Title	Time In	Time Out	Total Time In Facility (Minutes)	Patient Care Minutes	Productivity	Signature
11/1/14	Sally OT	OTR	8:00	4:00	A	B	A/B	Sally OT

Productivity Tracking

Sign-In Sheet / Productivity Form

Discipline: Speech Therapy

Facility: _____

Month: _____

Date	Name	Title	Time In	Time Out	Total Time In Facility (Minutes)	Patient Care Minutes	Productivity	Signature
11/1/14	Jenny ST	ST	8:00	4:00	A	B	A/B	Jenny ST

Labor Logs

Policy

The therapy labor log will be used to record time spent at the facility by all staff and contracted therapists, assistants and aides of all disciplines.

Scope

Information entered on this log will include:

1. The type of therapy service provided.

2. The time spent at the facility by therapists, assistants and aides.

Procedure

1. Initiate the therapy labor log at the beginning of each month billing cycle.

2. Maintain a separate labor log for:

    * Each therapy discipline.
    * Each therapy company (if applicable).

3. Maintain the log daily.

4. Submit a copy of the completed log to the facility business office on the last working day of the month.

5. Retain original log in the therapy department.

6. In the case that the therapy staff utilize the facility time clock to punch in and out those records would supersede this document.

7. The rehabilitation manager should obtain a copy of total rehabilitation staff hours at the end of each week to compare productivity sheets.

8. The department as a whole must do either the labor logs or time clock punches.

Labor Logs

Instructions

1. **Supplier** — Enter the name of the therapist or therapy agency providing service.

2. **Facility** — Enter the name of the facility.

3. **Number** — Enter the number of the facility.

4. **Type of Therapy** — Enter the type of therapy given, P.T., O.T., S.L.P.
A separate log must be prepared for each type of therapy.

5. **Month/Year** — Enter the month and year of service.

6. **Titles** — Enter the name of the:
   - Licensed registered therapist(s).
   - Therapist assistant(s)
   - Aides(s)

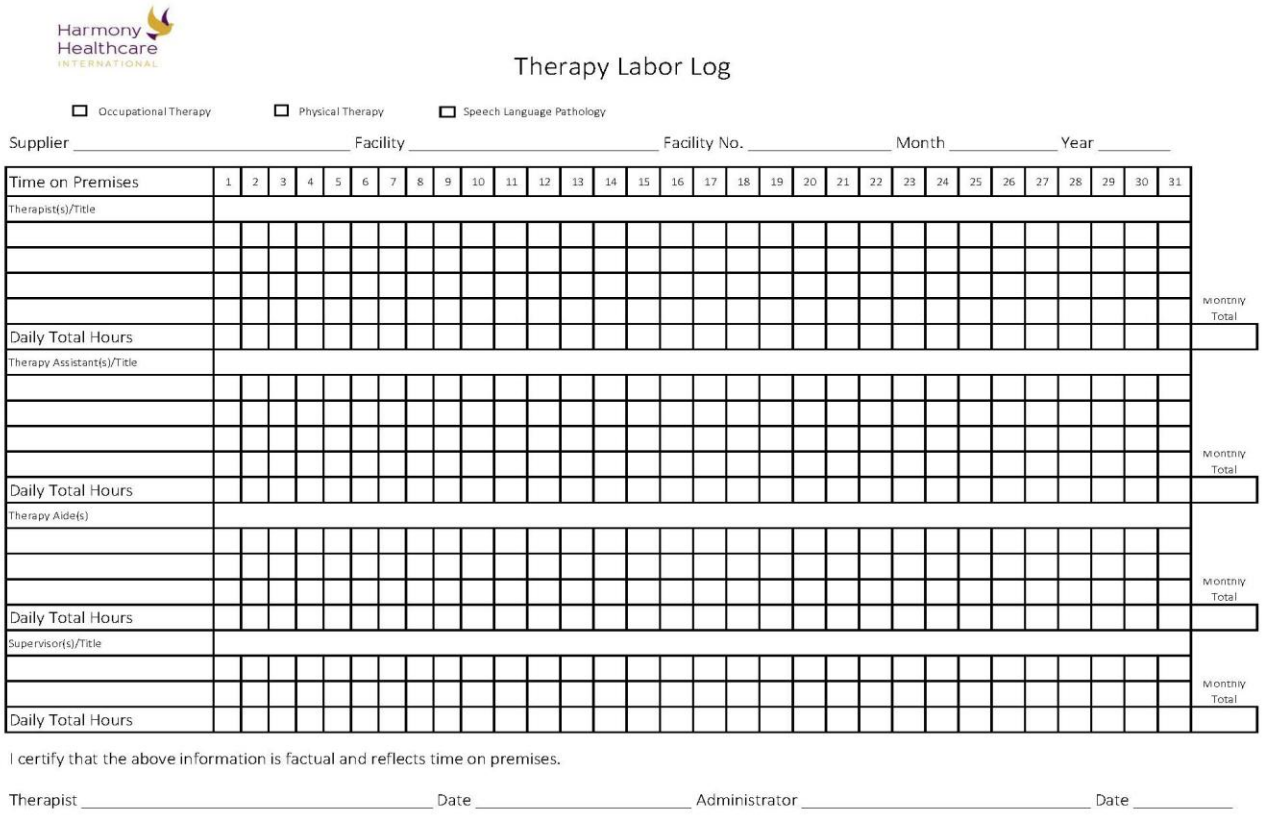
7. **Time on Premises** — This field identifies the hours spent at the facility each day. This includes time spent providing direct care, completing documentation, attending/performing in-services, attendance at care plan, department head meetings, etc.

   Do not include time spent traveling to and from the facility.

   Time spent completing documentation or paperwork outside the facility must not be included on the therapy labor log and is not reimbursable.

   Enter the total number of hours spent at the facility each day.

Labor Logs



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Therapy Labor Log

☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Language Pathology

Supplier _____ Facility _____ Facility No. _____ Month _____ Year _____

Time on Premises	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Therapist(s)/Title																																
																																Monthly Total
Daily Total Hours																																
Therapy Assistant(s)/Title																																
																																Monthly Total
Daily Total Hours																																
Therapy Aide(s)																																
																																Monthly Total
Daily Total Hours																																
Supervisor(s)/Title																																
																																Monthly Total
Daily Total Hours																																

I certify that the above information is factual and reflects time on premises.

Therapist _____ Date _____ Administrator _____ Date _____

Monthly Billing

Billing Requirements

Policy

The therapy staff will provide timely and accurate billing information to the facility MDS Coordinator and Business Office Manager

Overview

To assure that billing requirements for each month are met, all therapist are responsible for:

1. Submitting completed Therapy Services Logs and Labor Logs to the facility bookkeeper and Administrator on last working day of each month. This may occur via electronic billing software. It is no less important that these documents are completed in full and submitted to the facility bookkeeper.

Completing all sections of the required therapy documentation, recording correct billing dates and onset dates, Medical and treatment diagnosis coding, obtaining physician signatures and dates of signature on a timely basis.

Monthly Billing

Therapy Services Log

Policy

The Therapy Services Log will be used to record services performed by therapy staff employed by the facility and contracted therapists.

Scope

Information entered on this log will include:

1. Billing dates of the current month.
2. The therapy discipline providing service.
3. Evaluation units/minutes completed and totaled.
4. Total number of treatment sessions.
5. The number of minutes per evaluation/treatment.
6. ICD-9 code (Medical and Treatment).
7. Onset date.

Procedure

1. All therapy billing logs must be completed by each therapist providing treatment to a patient. Entries must be signed by the therapist providing treatment. Electronic signatures are acceptable with a policy for electronic signatures that meets Medicare requirements (contact software provider).
2. Initiate a Therapy Services Log at the beginning of each monthly billing cycle.
3. Maintain a separate services log for:
    - Each therapy discipline.
    - Part A, Part B, Medicaid, HMO, Private, or V.A. residents.
4. Maintain the log daily.
5. Submit a copy of completed log to the facility business office by the last working day of the month.
6. Facilities using an electronic system for billing will print or transmit to the Business Office on a facility's agreed upon frequency (bi-weekly, weekly, or monthly).
7. Retain original of the log in the therapy department.

Monthly Billing

Service Log Instructions

1. **Type of Therapy** — Enter the type of therapy used.
   - Physical
   - Occupational
   - Speech-Language Pathology
2. **Facility** — Enter the name of the facility.
3. **Services Date** — Enter the dates that reflect the first day of the current month and the last day of the current month.
4. **Resident Name** — List all residents treated by first and last name.
5. **ICD-10 Code** — Enter code number from diagnosis list.
6. **Type of Treatments** — Enter evaluation, first treatment and second treatment (for residents receiving treatments BID).
7. **Frequency of Treatment** — Enter under the appropriate date, the number of units per visit or evaluation. Note DC when treatment is terminated during the month.
8. **Various Payer Sources** — A separate log should be completed for Medicare A, Medicare B, or other (Private, HMO, V.A., or Goal-directed).
   - Tracking ACO patients is recommended.
9. **Onset Date** — List date that condition first occurred.

Physical Therapy Billing Log

Monthly Billing

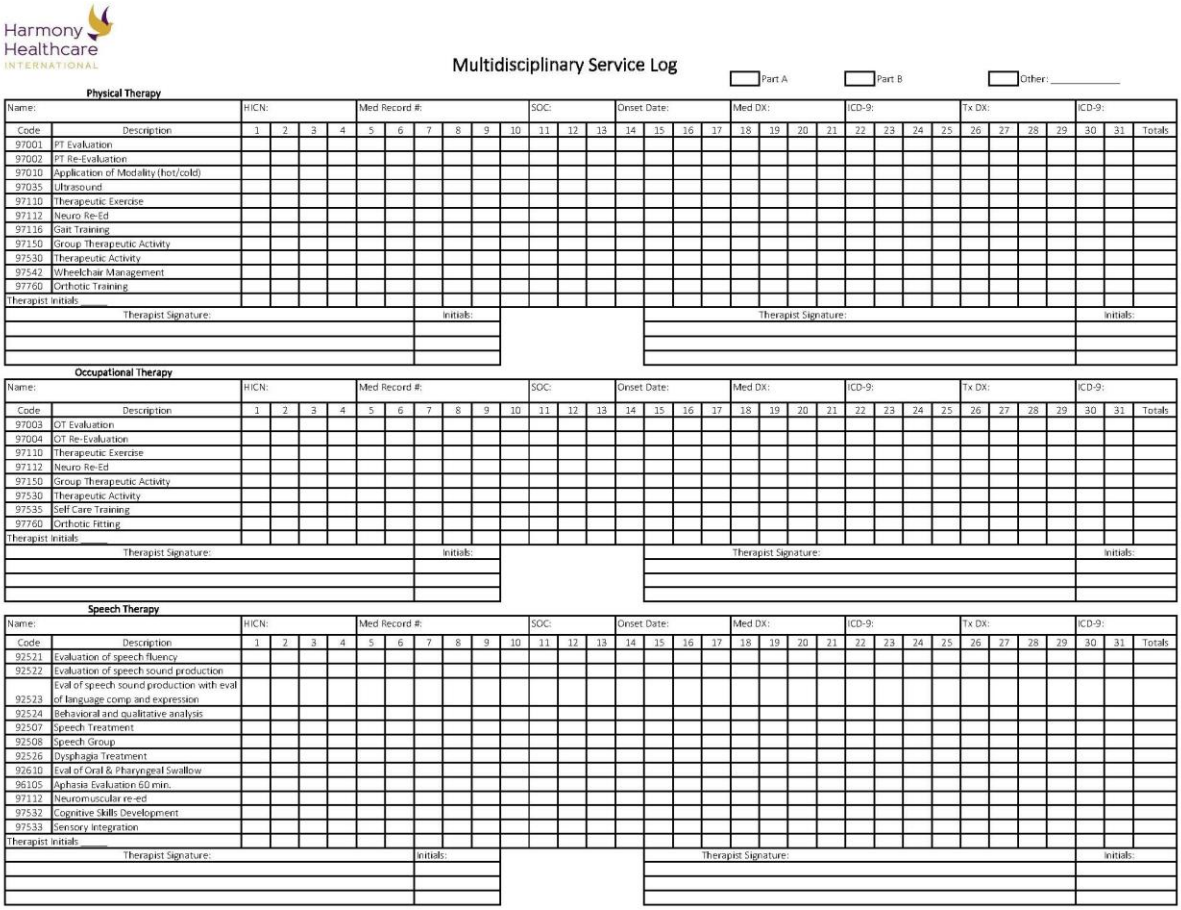
Occupational Therapy Billing Log

Monthly Billing

Speech Language Pathology Billing Log

Monthly Billing

Multidisciplinary Service Log



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Multidisciplinary Service Log

☐ Part A ☐ Part B ☐ Other: _____

Physical Therapy

Name:		HICN:				Med Record #:						SOC:			Onset Date:				Med DX:				ICD-9:				Tx DX:				ICD-9:		
Code	Description	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Totals
97001	PT Evaluation																																
97002	PT Re-Evaluation																																
97010	Application of Modality (hot/cold)																																
97035	Ultrasound																																
97110	Therapeutic Exercise																																
97112	Neuro Re-Ed																																
97116	Gait Training																																
97150	Group Therapeutic Activity																																
97530	Therapeutic Activity																																
97542	Wheelchair Management																																
97760	Orthotic Training																																
Therapist Initials ____																																	
Therapist Signature:								Initials:							Therapist Signature:															Initials:			

Occupational Therapy

Name:		HICN:				Med Record #:						SOC:			Onset Date:				Med DX:				ICD-9:				Tx DX:				ICD-9:		
Code	Description	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Totals
97003	OT Evaluation																																
97004	OT Re-Evaluation																																
97110	Therapeutic Exercise																																
97112	Neuro Re-Ed																																
97150	Group Therapeutic Activity																																
97530	Therapeutic Activity																																
97535	Self Care Training																																
97760	Orthotic Fitting																																
Therapist Initials ____																																	
Therapist Signature:								Initials:							Therapist Signature:															Initials:			

Speech Therapy

Name:		HICN:				Med Record #:						SOC:			Onset Date:				Med DX:				ICD-9:				Tx DX:				ICD-9:		
Code	Description	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Totals
92521	Evaluation of speech fluency																																
92522	Evaluation of speech sound production																																
92523	Eval of speech sound production with eval of language comp and expression																																
92524	Behavioral and qualitative analysis																																
92507	Speech Treatment																																
92508	Speech Group																																
92526	Dysphagia Treatment																																
92610	Eval of Oral & Pharyngeal Swallow																																
96105	Aphasia Evaluation 60 min.																																
97112	Neuromuscular re-ed																																
97532	Cognitive Skills Development																																
97533	Sensory Integration																																
Therapist Initials ____																																	
Therapist Signature:								Initials:							Therapist Signature:															Initials:			

Introduction to the Medical Review Process

CMS limits the amount it will pay in one calendar year for medically necessary outpatient (Part B) therapy services, including services furnished by a skilled nursing facility (SNF) to outpatients or residents not otherwise eligible for Part A benefits. The limit is called the "therapy cap." For the FY2016, the therapy cap limit is $1,960 for physical therapy (PT) and speech-language pathology (SLP) services combined; and $1,960 for occupational therapy (OT) services. As part of the exceptions process, there are additional limits known as "thresholds". The threshold amounts of $3,700 for PT and SLP combined and $3,700 for OT have been extended through December 31, 2017. For out-patient therapy services rendered above the threshold amounts, a Medicare contractor may review the medical records to check for medical necessity. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has eliminated the requirement for manual medical review for all claims exceeding the threshold. A targeted review process is currently being put into place. In addition, MACRA has eliminated the use of Recovery Auditors to conduct the reviews. CMS has commissioned Strategic Health Solutions as the Supplemental Medical Review Contractor (SMRC) with performing this medical review on a post-payment basis. Medical reviews analyze claims to determine provider compliance with Medicare coverage, coding and billing rules. Corrective action is taken when providers are found to be non-compliant. The goal of this process is to correct the behavior and prevent further inappropriate billing. The medical review process can be intimidating and overwhelming. Chapter 3 of the Medicare Program Integrity Manual– see below – provides a detailed overview of the post payment review process. Section 3.3.2.7 contains information specific to therapy services.

Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services
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(Rev. 3367, 10-07-15)

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

Language in this section is defined or described in Pub. 100-02, chapter 15, sections 220 and 230.

Section §1834(k)(5) to the Social Security Act (the Act), requires that all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998.

The Act also requires payment under a prospective payment system for outpatient rehabilitation services including CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- Comprehensive outpatient rehabilitation facilities (CORFs);
- Outpatient physical therapy providers (OPTs), also known as rehabilitation agencies;
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

NOTE: No provider or supplier other than the SNF will be paid for therapy services during the time the beneficiary is in a covered SNF Part A stay. For information regarding SNF consolidated billing see chapter 6, section 10 of this manual.

Similarly, under the HH prospective payment system, HHAs are responsible to provide, either directly or under arrangements, all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health POC. No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay. For information regarding HH consolidated billing see chapter10, section 20 of this manual.

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language

pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

In Chapter 23, as part of the CY 2009 Medicare Physician Fee Schedule Database, the descriptor for PC/TC indicator "7", as applied to certain HCPCS/CPT codes, is described as specific to the services of privately practicing therapists. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for CORF services identified by the HCPCS codes in §20. Assignment is mandatory.

The Medicare allowe d charge for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed
charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does not apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs) or hospitals in Maryland. CAHs are to be paid on a reasonable cost basis. Maryland hospitals are paid under the Maryland All-Payer Model.

Contractors process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, HHAs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the Regional Office (RO).
These provider types submit their claims to the contractors using the ASC X12 837 institutional claim format or the CMS-1450 paper form when permissible. Contractors also process claims from physicians, certain nonphysician practitioners (NPPs), therapists in private practices (TPPs), (which are limited to physical and occupational therapists, and speech-language pathologists in private practices), and physician-directed clinics that bill for services furnished incident to a physician's service (see Pub. 100-02,
Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to"). These provider types submit their claims to the contractor using the ASC X 12 837 professional claim format or the CMS-1500 paper form when permissible.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described).
Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that is paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

Contractors pay the nonfacility rate on institutional claims for services performed in the provider's facility. Contractors may pay professional claims using the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Contractors pay the codes in §20 under the MPFS on professional claims regardless of whether they may be considered rehabilitation services. However, contractors must use this list for institutional claims to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for any rehabilitation service.

Payment for rehabilitation therapy services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the TPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the contractor on a professional claim.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by TPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100- 02, Medicare Benefit Policy Manual, Chapter 15, for a definition of "incident to, therapist, therapy and related instructions.") Such services are billed to the contractor on the professional claim format. Assignment is mandatory.

Monthly Billing

The following table identifies the provider and supplier types, and identifies which claim format they may use to submit claims for outpatient therapy services to the contractor.

"Provider/Supplier Service " Type	Format	Bill Type	Comment
Inpatient SNF Part A	Institutional	21X	Included in PPS
Inpatient hospital Part B	Institutional	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B (audiology tests are not included)	Institutional	22X	SNF must provide and bill, or obtain under arrangements and bill.
Outpatient hospital	Institutional	13X	Hospital may provide and bill or obtain under arrangements and bill.
Outpatient SNF	Institutional	23X	SNF must provide and bill or obtain under arrangements and bill.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	Institutional	34X	Service not under home health plan of care.
Outpatient physical therapy providers (OPTs), also known as rehabilitation agencies	Institutional	74X	Paid MPFS for outpatient rehabilitation services.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Institutional	75X	Paid MPFS for outpatient rehabilitation services and all other services except drugs. Drugs are paid 95% of the AWP.

"Provider/Supplier Service " Type	Format	Bill Type	Comment
Physician, NPPs, TPPs, (therapy services in hospital or SNF)	Professional	See Chapter 26 for place of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. NOTE: Payment may be made to physicians and NPPs for their professional services defined as "sometimes therapy" (not part of a therapy plan) in certain situations; for example, when furnished to a beneficiary registered as an outpatient of a hospital.
Physician/NPP/TPPs office,	Professional	See Chapter	Paid via MPFS.
or patient's home		26 for place of service coding.	
Critical Access Hospital - inpatient Part B	Institutional	12X	Rehabilitation services are paid at cost.
Critical Access Hospital – outpatient Part B	Institutional	85X	Rehabilitation services are paid at cost.

Complete claim form completion requirements are contained in chapters 25 and 26. For a list of the outpatient rehabilitation HCPCS codes see §20.
If a contractor receives an institutional claim for one of these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its professional claims area to obtain the non-facility price in order to pay the claim.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. Contractors may consider other codes on institutional claims for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and could be performed within the scope of practice of the therapist providing the service.

10.1 - New Payment Requirement for A/B MACs (A)
(Rev. 1, 10-01-03)

Effective with claims with dates of service on or after July 1, 2003, OPTs/outpatient rehabilitation facilities (ORFs), (74X and 75X bill type) are required to report all their services utilizing HCPCS. A/B MACs (A) are required to make payment for these services under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine (see below for an explanation of these services).

The CMS currently provides A/B MACs (A) with a CORF supplemental file that contains all physician fee schedule services and their related prices. A/B MACs (A) use this file to price and pay OPT claims. The format of the record layout is provided in Attachment E of PM A-02-090, dated September 27, 2002. This is located in Chapter 23, section 50.3.

A/B MACs (A) will be notified in a one-time instruction of updates to this file and when it will be available for retrieval.

If an A/B MAC (A) receives a claim for one of the above HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the CORF supplemental file it currently uses to pay the CORF claims, it contacts its local A/B MAC (B) to obtain the price in order to pay the claim. When requesting the pricing data, it advises the A/B MAC (B) to provide it with the nonfacility fee.

10.2 - The Financial Limitation Legislation
(Rev. 2073, Issued: 10-22-10, Effective: 01-01-11, Implementation: 01-03-11)

A. Legislation on Limitations

The dollar amount of the limitations (caps) on outpatient therapy services is established by statute. The updated amount of the caps is released annually via Recurring Update Notifications and posted on the CMS Website www.cms.gov/TherapyServices, on contractor Websites, and on each beneficiary's Medicare Summary Notice. Medicare contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Act, required payment under a prospective payment system (PPS) for outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). Outpatient rehabilitation services include the following services:

- Physical therapy
- Speech-language pathology; and
- Occupational therapy.

Section 4541(c) of the BBA required application of financial limitations to all outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). In 1999, an annual per beneficiary limit of $1,500 was applied, including all outpatient physical therapy services and speech-language pathology services. A separate limit applied to all occupational therapy services. The limits were based on incurred expenses and included applicable deductible and coinsurance. The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

Since the limitations apply to outpatient services, they do not apply to skilled nursing facility (SNF) residents in a covered Part A stay, including patients occupying swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services covered under prospective payment systems for home health or inpatient hospitals, including critical access hospitals.

The limitation is based on therapy services the Medicare beneficiary receives, not the type of practitioner who provides the service. Physical therapists, speech-language pathologists, and occupational therapists, as well as physicians and certain nonphysician practitioners, could render a therapy service.

B. Moratoria and Exce ptions for Therapy Claims

Since the creation of therapy caps, Congress has enacted several moratoria. The Deficit Reduction Act of 2005 directed CMS to develop exceptions to therapy caps for calendar year 2006 and the exceptions have been extended periodically. The cap exception for therapy services billed by outpatient hospitals was part of the original legislation and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions.

10.3 - Application of Financial Limitations
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

(Additions, deletions or changes to the therapy code list are updated via a Recurring Update Notification)

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. References and polices relevant to the exceptions process in this chapter apply only when exceptions to therapy caps are in effect. For dates of service before October 1, 2012, limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on types of bill 12x or 13x, or 85x. Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than CAHs and hospitals in Maryland. During this period, only type of bill 12x claims with a CMS certification number in the CAH range, type of bill 12x and 13x claims with a CMS certification number beginning with the State code for Maryland, and type of bill 85x claims are excluded. Effective for dates of service on or after January 1, 2014, the limits also apply to CAHs. Effective for dates of service on or after January 1, 2016, the limits also apply to hospitals in Maryland.

Contractors apply the financial limitations to the MPFS amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year.

Medicare shall apply these financial limitations in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared system maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits.

10.3.1 - Exceptions to Therapy Caps – General
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. Except for the requirement to use the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Provider and supplier information concerning exceptions is in this chapter and in Pub. 100-02, Chapter 15, section 220.3. Exceptions shall be identified by a modifier on the claim and supported by documentation.

The beneficiary may qualify for use of the cap exceptions process at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection D. for use of the KX modifier.)

Use of the exception process does not exempt services from manual or other medical review processes as described in Pub. 100-08. Rather, atypical use of the exception process may invite contractor scrutiny, for example, when the KX modifier is applied to all services on claims that are below the therapy caps or when the KX modifier is used for all beneficiaries of a therapy provider. To substantiate the medical necessity of the therapy services, document in the medical record (see Pub. 100-02, chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection D., is added to claim lines to indicate that the clinician attests that services at and above the therapy caps are medically necessary and justification is documented in the medical record.

10.3.2 - Exceptions Process
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

No special documentation is submitted to the contractor for exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the exception because documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, chapter 15, section 220.3. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the exception, clinicians shall consider, for example, whether services are appropriate to--

The patient's condition, including the diagnosis, complexities, and severity; The services provided, including their type, frequency, and duration;
The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.

In addition, the following should be considered before using the exception process:

1. Exceptions for Evaluation Services

Evaluation. The CMS will except therapy evaluations from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services. For example, the following CPT codes for evaluation procedures may be appropriate:

92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.

These codes will continue to be reported as outpatient therapy procedures as listed in the Annual Therapy Update for the current year at:
http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.
They are not diagnostic tests. Definitions of evaluations and documentation are found in Pub. 100-02, chapter 15, sections 220 and 230.

Other Services. There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For

example, see the CSC - Therapy Cap Report, 3/21/2008, and CSC – Therapy Edits Tables 4/14/2008 at www.cms.hhs.gov/TherapyServices (Studies and Reports), or more recent utilization reports. Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency, and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier than is typical.
Conversely, professional literature and scientific reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

2. Exceptions for Medically Necessary Services

Clinicians may utilize the process for exception for any diagnosis or condition for which they can justify services exceeding the cap. Regardless of the diagnosis or condition, the patient must also meet other requirements for coverage.

Bill the most relevant diagnosis. As always, when billing for therapy services, the diagnosis code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment).
Where it is possible in accordance with State and local laws and the contractors' local coverage determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

The condition or complexity that caused treatment to exceed caps must be related to the therapy goals and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Documentation for an exception should indicate

how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.

If the contractor has determined that certain codes do not characterize patients who require medically necessary services, providers/suppliers may not use those codes, but must utilize a billable diagnosis code allowed by their contractor to describe the patient's condition. Contractors shall not apply therapy caps to services based on the patient's condition, but only on the medical necessity of the service for the condition. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

Contact your contractor for interpretation if you are not sure that a service is applicable for exception.

It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap. Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical or common sense. See Pub. 100-02, chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

NOTE: The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. For dates of service on or after October 1, 2012, therapy services furnished in an outpatient hospital are not excluded from the limitation.

10.3.3 - Use of the KX Modifier for Therapy Cap Exceptions
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a local coverage determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements for a given calendar year are listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- For professional claims, sent to the A/B MAC(B), refer to:
    - Pub.100-04, Medicare Claims Processing Manual, chapter 26, for more detail regarding completing Form CMS 1500, including the placement of HCPCS modifiers. **NOTE**: The Form CMS 1500 currently has space for providing four modifiers in block 24D, but, if the provider has more than four to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.
    - The ASC X12N 837 Health Care Claim: Professional Implementation Guide for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, and data elements SV101-3, SV101-4, SV101-5, and SV101-6. Copies of the ASC X12N 837 implementation guides may be obtained from the Washington Publishing Company.
    - For claims paid by a carrier or an A/B MAC(B), it is only appropriate to append the KX modifier to a service that reasonably may exceed the cap.

Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.

- For institutional claims, sent to the A/B MAC(A):

  - When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or OT), regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX modifier on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service.

  - Use the KX modifier on either all or none of the SLP lines on the claim, as appropriate. In contrast, if all the OT lines on the claim are below the cap, do not use the KX modifier on any of the OT lines, even when the KX modifier is appropriately used on all of the PT lines. Refer to Pub.100-04, Medicare Claims Processing Manual, chapter 25, for more detail.

By appending the KX modifier, the provider is attesting that the services billed:

Are reasonable and necessary services that require the skills of a therapist; (See Pub. 100-02, chapter 15, section 220.2); and

Are justified by appropriate documentation in the medical record, (See Pub. 100- 02, chapter 15, section 220.3); and

Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

When the KX modifier is appended to a therapy HCPCS code, the contractor will override the CWF system reject for services that exceed the caps and pay the claim if it is otherwise payable.

Providers and suppliers shall continue to append correct coding initiative (CCI) HCPCS modifiers under current instructions.

If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. In cases where appending the KX modifier would have been appropriate, contractors may reopen and/or adjust the claim, if it is brought to their attention.

Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

10.3.4 - Therapy Cap Manual Review Threshold
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

Beginning calendar year 2012, there shall be two total therapy service thresholds of $3700 per year: one annual threshold each for

(1) Occupational therapy services.

(2) Physical therapy services and speech-language pathology services combined.

Services shall accrue annually toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Contractors shall apply the thresholds to claims exceeding it by suspending the claim for manual review. Instructions regarding the manual review process may be found in Pub. 100-08, Medicare Program Integrity Manual.

10.3.5 - Identifying the Certifying Physician
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

Therapy plans of care must be certified by a physician or non-physician practitioner (NPP), per the requirements in the Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 220.1.3. Further, the National Provider Identifier (NPI) of the certifying physician/NPP identified for a therapy plan of care must be included on the therapy claim.

For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. At the time the certifying physician/NPP is identified for a therapy plan of care, private practice therapists (PPTs), physicians or NPPs, as appropriate, submitting therapy claims, are to treat it as if a referral has occurred for purposes of completing the claim and to follow the instructions in the appropriate ASC X12 837 Professional Health Care Claim Technical Report 3 (TR3) for reporting a referring provider (for paper claims, they are to follow the instructions for identifying referring providers per chapter 26 of this manual). These instructions include requirements for reporting NPIs.

Currently, in the 5010 version of the ASC X12 837 Professional Health Care Claim TR3, referring providers are first reported at the claim level; additional referring providers are reported at the line level only when they are different from that identified at the claim level. Therefore, there will be at least one referring provider identified at the claim level on the ASC X12 837 Professional claim for therapy services. However, because of the hierarchical nature of the ASC X12 837 health care claim transaction, and the possibility of other types of referrals applying to the claim, the number of referring providers identified on a professional claim may vary. For example, on a claim where one physician/NPP has certified all the therapy plans of care, and there are no other referrals, there would be only one referring provider identified at the claim level and none at the line levels. Conversely, on a claim also containing a non-therapy referral made by a different physician/NPP than the one certifying the therapy plan of care, the billing provider may elect to identify either the nontherapy or the therapy referral at the claim level, with the other referral(s) at the line levels. Similarly, on a claim having different certifying physician/NPPs for different therapy plans of care, only one of these physician/NPPs will be identified at the claim level, with the remainder identified at the line levels. These scenarios are only examples: there may be other patterns of representing referring providers at the claim and line levels depending upon the circumstances of the care and the manner in which the provider applies the requirements of the ASC X12 837 Professional Health Care Claim TR3.

For situations where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service, he/she supplies his/her own information, including the NPI, in the appropriate referring provider loop (or, appropriate block on Form CMS 1500). This is applicable to those therapy services that are personally furnished by the physician/NPP as well as to those services that are furnished incident to their own and delivered by “qualified personnel” (see section 230.5 of this manual for qualifications for incident to personnel).

Contractors shall edit to ensure that there is at least one claim-level referring provider identified on professional therapy claims, and shall use the presence of the therapy modifiers (GN, GP, GO) to identify those claims subject to this requirement.

For the purposes of processing institutional claims, the certifying physician/NPP and their NPI are reported in the Attending Provider fields on institutional claim formats. Since the physician/NPP is certifying the therapy plan of care for the services on the claim, this is consistent with the National Uniform Billing Committee definition of the Attending Provider as “the individual who has overall responsibility for the patient’s medical care and treatment” that is reported on the claim. In cases where a patient is receiving care under more than one therapy plan of care (OT, PT, or SLP) with different certifying

physicians/NPPs, the second certifying physicians/NPP and their NPI are reported in the Referring Physician fields on institutional claim formats.

10.3.6 - MSN Messages Regarding the Therapy Cap
(Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

Existing MSN messages 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services. Contractors add the applied amount for individual beneficiaries and the generic limit amount to all MSNs that require them. For details of these MSNs, see: http://www.cms.gov/MSN/02_MSN%20Messages.asp.

10.4 - Claims Processing Requirements for Financial Limitations
(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

A Re quire me nts – Institutional Claims

Regardless of financial limits on therapy services, CMS requires modifiers (See section 20.1 of this chapter) on specific codes for the purpose of data analysis. Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. When outpatient hospital therapy services are excluded from the limitation, the beneficiary must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital's provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital.

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X and 75X using the MPFS allowed amount (before adjustment for beneficiary liability).

For SNFs, the financial limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility, i.e., one that is either certified by Medicare alone, or is dually certified by Medicare as a SNF and by Medicaid as a nursing facility (NF). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare- certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, services furnished to SNF residents who are in a non-Medicare certified section of the facility, i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program, use bill type 23X. For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents who go to the SNF for outpatient treatment (bill type 23X), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded when outpatient hospital therapy services are excluded from the limitation.

B. Re quirements - Professional Claims

Claims containing any of the "always therapy" codes should have one of the therapy modifiers appended (GN, GO, GP). When any code on the list of therapy codes is submitted with specialty codes "65" (physical therapist in private practice), "67" (occupational therapist in private practice), or "15" (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. Contractors shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The CMS identifies certain codes listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as "sometimes therapy" services, regardless of the presence of a financial limitation. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50" (Nurse Practitioner), "89," (Clinical Nurse Specialist), and "97," (Physician Assistant) may be processed without therapy modifiers when they are not therapy services. On review of these claims, "sometimes therapy" services that are not accompanied by a therapy modifier must be documented, reasonable and necessary, and payable as physician or nonphysician practitioner services, and not services that the contractor interprets as therapy services.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier.

C. Contractor Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, contractors are responsible for assuring that payment does not exceed the financial limitations, when the limits are in effect, except as noted below.

In cases where a claim line partially exceeds the limit, the contractor must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the "Financial Limitation" field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

Example:

Services received to date are $15 under the limit. There is a $15 allowed amount remaining that Medicare will cover before the cap is reached.

Incoming claim: Line 1 MPFS allowed amount is $50.
Line 2 MPFS allowed amount is $25. Line 3, MPFS allowed amount is $30.

Based on this example, lines 1 and 3 are denied and line 2 is paid. The contractor reports in the "Financial Limitation" field of the CWF record "$25.00 along with the CWF override code. The contractor always applies the amount that would least exceed the limit. Since institutional claims systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

D. Additional Information for Contractors During the Time Financial Limits Are in Effect With or Without Exceptions

Once the limit is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services that exceed the limit should be denied. The contractors use claim adjustment reason code 119 - Benefit maximum for this time period or occurrence has been reached- in the provider remittance advice to establish the reason for denial. Provider liability (group code CO) or beneficiary liability (group code PR) are reported on the remittance advice as defined by section 10.5.

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider/supplier should bill the usual and customary charges for the services furnished even though such charges might exceed the

limit. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

Because CWF applies the financial limitation according to the date when the claim was received (when the date of service is within the effective date range for the limitation), it is possible that the financial limitation will have been met before the date of service of a given claim. Such claims will prompt the CWF error code and subsequent contractor denial.

When the provider/supplier knows that the limit has been reached, and exceptions are either not appropriate or not available, further billing should not occur. The provider/supplier should inform the beneficiary of the limit and their option of receiving further covered services from an outpatient hospital when outpatient hospital therapy services are excluded from the limitation (unless consolidated billing rules prevent the use of the outpatient hospital setting). If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

If a beneficiary elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination is subject to the administrative appeals process as described in subsection C. of section 10.3 and Pub. 100-04, Chapter 29.

10.5 - Notification for Beneficiaries Exceeding Financial Limitations (Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation: 10-07-13)

A. Notice to Beneficiaries

Contractors will advise providers/suppliers to notify beneficiaries of the therapy financial limitations at their first therapy encounter with the beneficiary. Prior to 2013, Medicare instructed providers/suppliers to inform beneficiaries that beneficiaries were responsible for 100 percent of the costs of therapy services above each respective therapy limit (cap), unless this outpatient care was furnished directly or under arrangements by a hospital when outpatient hospital therapy services were excluded from the limitation. The American Taxpayer Relief Act (ATRA) of 2012 amended §1833(g)(5) of the Social Security Act (the Act) providing limitation of liability protections (under §1879 of the Act) to beneficiaries with respect to outpatient therapy services that exceed therapy cap amounts, furnished on or after January 1, 2013. Thus, effective January 1, 2013, assignment of liability has changed for therapy services exceeding the cap that don't qualify for a coverage exception. The provider/supplier is financially responsible when Medicare denies payment for therapy services above the cap that don't qualify for a coverage exception unless a valid Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, was issued per CMS guidelines.

Providers were previously encouraged to use either a form of their own design or a voluntary ABN when providing therapy above the cap where no exception was applied; however, this instruction is no longer valid. When providing therapy services above the cap that don't qualify for the exceptions process, the provider/supplier must now issue a mandatory ABN in order to transfer financial responsibility to the beneficiary. When the ABN is used as a mandatory notice, providers must adhere to the ABN form instructions and guidance published in Chapter 30, Section 50 of this manual. The ABN and instructions can be found at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

When issuing the ABN for therapy in excess of therapy caps, the following language is suggested for the "Reason Medicare May Not Pay" section: "Medicare won't pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap) in (add the year or the dates of service to which it applies) unless you qualify for an exception to this cap amount. Your services don't qualify for an exception. " Providers should use similar language for occupational therapy services when appropriate. A cost estimate for the services should be included per the ABN form instructions. Therapy cost estimates can be listed as a cost per service or as a projected total cost for a certain amount of therapy provided over a specified time period.

ABN issuance remains mandatory before the cap is exceeded when services aren't expected to be covered by Medicare because they are not medically reasonable and necessary. When the clinician determines that skilled services are not medically necessary, the clinical goals have been met, or there is no longer potential for the rehabilitation of health and/or function in a reasonable time, the beneficiary should be informed. If the beneficiary will be getting services that don't meet the medical necessity requirements for Medicare payment, the ABN must be issued prior to delivering these services. The ABN informs the beneficiary of his/her potential financial obligation to the provider, allows him/her to choose whether or not to get the services, and provides information regarding appeal rights.

When a provider/supplier expects that Medicare will deny payment on a claim for therapy services because they are not medically reasonable and necessary, regardless of whether or not therapy limits are met, the ABN must be issued before providing the services in order to transfer financial responsibility to the beneficiary.

10.6 - Functional Reporting
(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

A General

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the Act to require a claims-based data collection system for outpatient therapy services, including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. 42 CFR 410.59, 410.60, 410.61, 410.62 and 410.105 implement this requirement. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures.

Beneficiary unction information is reported using 42 nonpayable functional G-codes and seven severity/complexity modifiers on claims for PT, OT, and SLP services. Functional reporting on one functional limitation at a time is required periodically throughout an entire PT, OT, or SLP therapy episode of care.

The nonpayable G-codes and severity modifiers provide information about the beneficiary's functional status at the outset of the therapy episode of care, including projected goal status, at specified points during treatment, and at the time of discharge.
These G-codes, along with the associated modifiers, are required at specified intervals on all claims for outpatient therapy services – not just those over the cap.

B. Application of New Coding Re quire ments

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. A testing period will be in effect from January 1, 2013, until July 1, 2013, to allow providers and practitioners to use the new coding requirements to assure that systems work. Claims for therapy services furnished on and after July 1, 2013, that do not contain the required functional G-code/modifier information will be returned or rejected, as applicable.

C. Services Affected

These requirements apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the CORF benefit. They also apply to the therapy services furnished personally by and incident to the service of a physician or a nonphysician practitioner (NPP), including a nurse practitioner (NP), a certified nurse specialist (CNS), or a physician assistant (PA), as applicable.

D. Providers and Practitioners Affected.

The functional reporting requirements apply to the therapy services furnished by the following providers: hospitals, CAHs, SNFs, CORFs, rehabilitation agencies, and HHAs (when the beneficiary is not under a home health plan of care). It applies to the following practitioners: physical therapists, occupational therapists, and speech-language

pathologists in private practice (TPPs), physicians, and NPPs as noted above. The term "clinician" is applied to these practitioners throughout this manual section. (See definition section of Pub. 100-02, Chapter 15, section 220.)

E Function-related G-codes

There are 42 functional G-codes, 14 sets of three codes each. Six of the G-code sets are generally for PT and OT functional limitations and eight sets of G-codes are for SLP functional limitations.

The following G-codes are for functional limitations typically seen in beneficiaries receiving PT or OT services. The first four of these sets describe categories of functional limitations and the final two sets describe "other" functional limitations, which are to be used for functional limitations not described by one of the four categories.

NONPAYABLE G-CODES FOR FUNCTIONAL LIMITATIONS

Code	Long Descriptor	Short Descriptor
Mobility G-code Set		
G8978	Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals	Mobility current status
G8979	Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Mobility goal status
G8980	Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting	Mobility D/C status
Changing & Maintaining Body Position G-code Set		
G8981	Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals	Body pos current status
G8982	Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Body pos goal status
G8983	Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting	Body pos D/C status

Carrying, Moving & Handling Objects G-code Set		
G8984	Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals	Carry current status
G8985	Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Carry goal status
G8986	Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting	Carry D/C status
Self Care G-code Set		
G8987	Self care functional limitation, current status, at therapy episode outset and at reporting intervals	Self care current status
G8988	Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Self care goal status
G8989	Self care functional limitation, discharge status, at discharge from therapy or to end reporting	Self care D/C status

The following "other PT/OT" functional G-codes are used to report:

- a beneficiary's functional limitation that is not defined by one of the above four categories;
- a beneficiary whose therapy services are not intended to treat a functional limitation;
- or a beneficiary's functional limitation when an overall, composite or other score from a functional assessment too is used and it does not clearly represent a functional limitation defined by one of the above four code sets.

Code	Long Descriptor	Short Descriptor
Other PT/OT Primary G-code Set		
G8990	Other physical or occupational therapy primary functional limitation, current status, at therapy episode outset and at reporting intervals	Other PT/OT current status
G8991	Other physical or occupational therapy primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Other PT/OT goal status
G8992	Other physical or occupational therapy primary functional limitation, discharge status, at discharge from therapy or to end reporting	Other PT/OT D/C status
Other PT/OT Subsequent G-code Set		
G8993	Other physical or occupational therapy subsequent functional limitation, current status, at therapy episode outset and at reporting intervals	Sub PT/OT current status
G8994	Other physical or occupational therapy subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Sub PT/OT goal status

The following G-codes are for functional limitations typically seen in beneficiaries receiving SLP services. Seven are for specific functional communication measures, which are modeled after the National Outcomes Measurement System (NOMS), and one is for any "other" measure not described by one of the other seven.

Code	Long Descriptor	Short Descriptor
Swallowing G-code Set		
G8996	Swallowing functional limitation, current status, at therapy episode outset and at reporting intervals	Swallow current status
G8997	Swallowing functional limitation, projected goal	Swallow goal status

Code	Long Descriptor	Short Descriptor
	status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	
G8998	Swallowing functional limitation, discharge status, at discharge from therapy or to end reporting	Swallow D/C status
Motor Speech G-code Set (Note: These codes are not sequentially numbered)		
G8999	Motor speech functional limitation, current status, at therapy episode outset and at reporting intervals	Motor speech current status
G9186	Motor speech functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Motor speech goal status
G9158	Motor speech functional limitation, discharge status, at discharge from therapy or to end reporting	Motor speech D/C status
Spoken Language Comprehension G-code Set		
G9159	Spoken language comprehension functional limitation, current status, at therapy episode outset and at reporting intervals	Lang comp current status
G9160	Spoken language comprehension functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Lang comp goal status
G9161	Spoken language comprehension functional limitation, discharge status, at discharge from therapy or to end reporting	Lang comp D/C status
Spoken Language Expressive G-code Set		
G9162	Spoken language expression functional limitation, current status, at therapy episode outset and at reporting intervals	Lang express current status
G9163	Spoken language expression functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Lang press goal status
G9164	Spoken language expression functional limitation, discharge status, at discharge from therapy or to end reporting	Lang express D/C status
Attention G-code Set		
G9165	Attention functional limitation, current status, at therapy episode outset and at reporting intervals	Atten current status

G9166	Attention functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Atten goal status
G9167	Attention functional limitation, discharge status, at discharge from therapy or to end reporting	Atten D/C status
Memory G-code Set		

Code	Long Descriptor	Short Descriptor
G9168	Memory functional limitation, current status, at therapy episode outset and at reporting intervals	Memory current status
G9169	Memory functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Memory goal status
G9170	Memory functional limitation, discharge status, at discharge from therapy or to end reporting	Memory D/C status
Voice G-code Set		
G9171	Voice functional limitation, current status, at therapy episode outset and at reporting intervals	Voice current status
G9172	Voice functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Voice goal status
G9173	Voice functional limitation, discharge status, at discharge from therapy or to end reporting	Voice D/C status

The following "other SLP" G-code set is used to report:

- on one of the other eight NOMS-defined functional measures not described by the above code sets; or

- to report an overall, composite or other score from assessment tool that does not clearly represent one of the above seven categorical SLP functional measures.

Code	Long Descriptor	Short Descriptor
Other Speech Language Pathology G-code Set		
G9174	Other speech language pathology functional limitation, current status, at therapy episode outset and at reporting intervals	Speech lang current status
G9175	Other speech language pathology functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Speech lang goal status
G9176	Other speech language pathology functional limitation, discharge status, at discharge from therapy or to end reporting	Speech lang D/C status

F. Severity/Complexity Modifiers

For each nonpayable functional G-code, one of the modifiers listed below must be used to report the severity/complexity for that functional limitation.

Modifier	Impairment Limitation Restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the clinician furnishing the therapy services.

G. Required Reporting of Functional G-codes and Severity Modifiers

The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).

Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

- At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service);
- At least once every 10 treatment days, which corresponds with the progress reporting period;
- When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004) is furnished and billed;
- At the time of discharge from the therapy episode of care–(i.e., on the date services related to the discharge [progress] report are furnished); and

- At the time reporting of a particular functional limitation is ended in cases where the need for further therapy is necessary.

- At the time reporting is begun for a new or different functional limitation within the same episode of care (i.e., after the reporting of the prior functional limitation is ended)

Functional reporting is required on claims throughout the entire episode of care. When the beneficiary has reached his or her goal or progress has been maximized on the initially selected functional limitation, but the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes. In these situations two or more functional limitations will be reported for a beneficiary during the therapy episode of care. Thus, reporting on more than one functional limitation may be required for some beneficiaries but not simultaneously.

When the beneficiary stops coming to therapy prior to discharge, the clinician should report the functional information on the last claim. If the clinician is unaware that the beneficiary is not returning for therapy until after the last claim is submitted, the clinician cannot report the discharge status.

When functional reporting is required on a claim for therapy services, two G-codes will generally be required.

Two exceptions exist:

1. Therapy services under more than one therapy POC-- Claims may contain more than two nonpayable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.

2. One-Time Therapy Visit-- When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

Each reported functional G-code must also contain the following line of service information:

- Functional severity modifier

- Therapy modifier indicating the related discipline/POC -- GP, GO or GN -- for PT, OT, and SLP services, respectively

- Date of the related therapy service

- Nominal charge, e.g., a penny, for institutional claims submitted to the A/B MACs (A). For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

NOTE: The KX modifier is not required on the claim line for nonpayable G-codes, but would be required with the procedure code for medically necessary therapy services furnished once the beneficiary's annual cap has been reached.

The following example demonstrates how the G-codes and modifiers are used. In this example, the clinician determines that the beneficiary's mobility restriction is the most clinically relevant functional limitation and selects the Mobility G-code set (G8978 –

G8980) to represent the beneficiary's functional limitation. The clinician also determines the severity/complexity of the beneficiary's functional limitation and selects the appropriate modifier. In this example, the clinician determines that the beneficiary has a 75 percent mobility restriction for which the CL modifier is applicable. The clinician expects that at the end of therapy the beneficiaries will have only a 15 percent mobility restriction for which the CI modifier is applicable. When the beneficiary attains the mobility goal, therapy continues to be medically necessary to address a functional limitation for which there is no categorical G-code. The clinician reports this using (G8990 – G8992).

At the outset of therapy-- On the DOS for which the initial evaluative procedure is furnished or the initial treatment day of a therapy POC, the claim for the service will also include two G-codes as shown below.

- G8978-CL to report the functional limitation (Mobility with current mobility limitation of "at least 60 percent but less than 80 percent impaired, limited or restricted")

- G8979-CI to report the projected goal for a mobility restriction of "at least 1 percent but less than 20 percent impaired, limited or restricted."

At the end of each progress reporting period-- On the claim for the DOS when the services related to the progress report (which must be done at least once each 10 treatment days) are furnished, the clinician will report the same two G-codes but the modifier for the current status may be different.

- G8978 with the appropriate modifier are reported to show the beneficiary's current status as of this DOS. So if the beneficiary has made no progress, this claim will include G8978-CL. If the beneficiary made progress and now has a mobility restriction of 65 percent CL would still be the appropriate modifier for 65 percent, and G8978-CL would be reported in this case. If the beneficiary now has a mobility restriction of 45 percent, G8978-CK would be reported.

- G8979-CI would be reported to show the projected goal. This severity modifier would not change unless the clinician adjusts the beneficiary's goal.

This step is repeated as necessary and clinically appropriate, adjusting the current status modifier used as the beneficiary progresses through therapy.

At the time the beneficiary is discharged from the therapy episode. The final claim for therapy episode will include two G-codes.

- G8979-CI would be reported to show the projected goal. G8980-CI would be reported if the beneficiary attained the 15 percent mobility goal. Alternatively, if the

beneficiary's mobility restriction only reached 25 percent; G8980-CJ would be reported.

To end reporting of one functional limitation-- As noted above, functional reporting is required to continue throughout the entire episode of care. Accordingly, when further therapy is medically necessary after the beneficiary attains the goal for the first reported functional limitation, the clinician would end reporting of the first functional limitation by using the same G-codes and modifiers that would be used at the time of discharge.
Using the mobility example, to end reporting of the mobility functional limitation, G8979-CI and G8980-CI would be reported on the same DOS that coincides with end of that progress reporting period.

To begin reporting of a second functional limitation. At the time reporting is begun for a new and different functional limitation, within the same episode of care (i.e., after the reporting of the prior functional limitation is ended). Reporting on the second functional limitation, however, is not begun until the DOS of the next treatment day -- which is day one of the new progress reporting period. When the next functional limitation to be reported is NOT defined by one of the other three PT/OT categorical codes, the G-code set (G8990 - G8992) for the "other PT/OT primary" functional limitation is used, rather than the G-code set for the "other PT/OT subsequent" because it is the first reported "other PT/OT" functional limitation. This reporting begins on the DOS of the first treatment day following the mobility "discharge" reporting, which is counted as the initial service for the "other PT/OT primary" functional limitation and the first treatment day of the new progress reporting period. In this case, G8990 and G8991, along with the corresponding modifiers, are reported on the claim for therapy services.

The table below illustrates when reporting is required using this example and what G- codes would be used.

Example of Required Re porting

Key: Reporting Period (RP)	Begin RP #1 for Mobility at Episode Outset	End RP#1for Mobility at Progress Report	Mobility RP #2 Begins Next Treatment Day	End RP #2 for Mobility at Progress Report	Mobility RP #3 Begins Next Treatment Day	D/C or End Reporting for Mobility	Begin RP #1 for Other PT/OT Primary
Mobility: Walking & Moving Around							
G8978 – Current Status	X	X		X			
G 8979– Goal Status	X	X		X		X	
G8980 – Discharge Status						X	
Other PT/OT Primary							
G8990 – Current Status							X
G8991 – Goal Status							X
G8992 – Discharge Status							

Key: Reporting Period (RP)	Begin RP #1 for Mobility at Episode Outset	End RP#1for Mobility at Progress Report	Mobility RP #2 Begins Next Treatment Day	End RP #2 for Mobility at Progress Report	Mobility RP #3 Begins Next Treatment Day	D/C or End Reporting for Mobility	Begin RP #1 for Other PT/OT Primary
No Functional Reporting Required			X		X		

H. Required Tracking and Documentation of Functional G-codes and Severity Modifiers

The clinician who furnishes the services must not only report the functional information on the therapy claim, but, he/she must track and document the G-codes and severity modifiers used for this reporting in the beneficiary's medical record of therapy services.

For details related to the documentation requirements, refer to, Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, section 220.4 - Functional Reporting. For coverage rules related to MCTRJCA and therapy goals, refer to Pub. 100-02: a) for outpatient therapy services, see Chapter 15, section 220.1.2 B and b) for instructions specific to PT, OT, and SLP services in the CORF, see Chapter 12, section 10.

10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services (Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

Full payment is made for the unit or procedure with the highest PE payment.

For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or Form CMS-1450).

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.
When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The therapy payment amount that has been reduced by the MPPR is applied toward the therapy caps described in section 10.2. As a result, the MPPR may increase the amount of medically necessary therapy services a beneficiary may receive before exceeding the caps. The reduced amount is also used to calculate the beneficiary's coinsurance and deductible amounts.

Contractors indicate services have been subject to the MPPR using the following coding on the provider's remittance advice:

- Group code CO and
- Claim adjustment reason code 59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)

Contractors shall use the following message on Medicare Summary Notices for claims subject to the MPPR:

- 30.1 The approved amount is based on a special payment method, or
- 30.1 La cantidad aprobada está basada en un método especial de pago.

20 - HCPCS Coding Requirement
(Rev. 1850, Issued: 11-13-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Uniform Coding

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The current Healthcare Common Procedure Coding System/Current Procedural Terminology is used for the reporting of these services. The uniform coding requirement in the Act is specific to payment for all CORF services and outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology - that is provided and billed to Medicare contractors. The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the non facility rate.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS/CPT for outpatient rehabilitation and CORF services began using HCPCS to report these services. This requirement does not apply to outpatient rehabilitation services provided by:

- Critical access hospitals, which are paid on a cost basis, not MPFS;
- RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or
- Providers that do not furnish therapy services.

The following "providers of services" must bill the A/B MAC (A) for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF);
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC).
- Comprehensive outpatient rehabilitation facilities (CORFs); and
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient physical therapy facilities in this instruction).

Note 1. The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

Note 2. For HHAs, HCPCS/CPT coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a home health plan of care.

The following practitioners must bill the A/B MAC (B) for outpatient rehabilitation therapy services using HCPCS/CPT codes:

- Physical therapists in private practice (PTPPs),
- Occupational therapists in private practice (OTPPs),
- Speech-language pathologists in private practice (SLPPs),
- Physicians, including MDs, DOs, podiatrists and optometrists, and
- Certain nonphysician practitioners (NPPs), acting within their State scope of practice, e.g., nurse practitioners and clinical nurse specialists.

Providers billing to intermediaries shall report:

- The date the therapy plan of care was either established or last reviewed (see §220.1.3B) in Occurrence Code 17, 29, or 30.
- The first day of treatment in Occurrence Code 35, 44, or 45.

B. Applicable Outpatient R habilitation HCPCS Codes

The CMS identifies the codes listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech-language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology.

When in effect, any financial limitation will also apply to services represented unless otherwise noted on the therapy page on the CMS Web site.

C. Additional HCPCS Codes

Some HCPCS/CPT codes that are not on the list of therapy services should not be billed with a modifier. For example, outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either "incident to" services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions, they are considered therapy services and must meet the other conditions for physical and occupational therapy. The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000 - 97799 series and the corresponding therapy modifier, GP or GO, must be used.

Another example of codes that are not on the list of therapy services and should not be billed with a therapy modifier includes the following HCPCS codes: 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, and 95934. These services represent diagnostic services - not therapy services; they must be appropriately billed and shall not include therapy modifiers.

Other codes not on the therapy code list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service). One example of non-listed codes where a therapy modifier is indicated regards the provision of services described in the CPT code series, 29000 through 29590, for the application of casts and strapping. Some of these codes previously appeared on the therapy code list, but were deleted because we determined that they represented services that are most often performed outside a therapy plan of care. However, when these services are provided by therapists or as an integral part of a therapy plan of care, the CPT code must be accompanied with the appropriate therapy modifier.

NOTE: The above lists of HCPCS/CPT codes are intended to facilitate the contractor's ability to pay claims under the MPFS. It is not intended to be an exhaustive list of covered services, imply applicability to provider settings, and does not assure coverage of these services.

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims (Rev. 2868, Issued: 02-06-14, Effective: 07-01-14, Implementation: 07-07-14)

Modifiers are used to identify therapy services whether or not financial limitations are in effect. When limitations are in effect, the CWF tracks the financial limitation based on

the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted in §20 of this chapter. Consult §20 for the list of codes to which modifiers must be applied. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GN Services delivered under an outpatient speech-language pathology plan of care;
- GO Services delivered under an outpatient occupational therapy plan of care; or,
- GP Services delivered under an outpatient physical therapy plan of care.

This is applicable to all claims from physicians, nonphysician practitioners (NPPs), PTPPs, OTPPs, SLPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services as noted on the applicable code list in §20 of this chapter.

Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.

Contractors edit institutional claims to ensure the following:

- that a GN, GO or GP modifier is present for all lines reporting revenue codes 042X, 043X, or 044X.
- that no more than one GN, GO or GP modifier is reported on the same service line.
- that revenue codes and modifiers are reported only in the following combinations:
  - Revenue code 42x (physical therapy) lines may only contain modifier GP
  - Revenue code 43x (occupational therapy) lines may only contain modifier GO
  - Revenue code 44x (speech-language pathology) lines may only contain modifier GN.
- that discipline-specific evaluation and re-evaluation HCPCS codes are always reported with the modifier for the associated discipline (e.g. modifier GP with a HCPCS code for a physical therapy evaluation).

Contractors return to the provider institutional claims that do not meet one or more of these conditions.

20.2 - Reporting of Service Units With HCPCS

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

A Gene ral

Effective with claims submitted on or after April 1, 1998, providers billing on the ASC X12 837 institutional claim format or Form CMS-1450 were required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500, and CORFs were required to report their full range of CORF services on the institutional claim. These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.

B. Timed and Untime d Codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

EXAMPLE: A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code 92521. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single cale ndar day** using CPT codes and the appropriate number of 15 minute units of service.

EXAMPLE: A beneficiary received occupational therapy (HCPCS "timed" code 97530 which is defined in 15 minute units) for a total of 60 minutes. The provider would then report revenue code 043X and 4 units.

C. Counting Minute s for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units Number of Minute s

1 unit: ≥ 8 minutes through 22 minutes

2 units: ≥ 23 minutes through 37 minutes

3 units: ≥ 38 minutes through 52 minutes

4 units: ≥ 53 minutes through 67 minutes

5 units: ≥ 68 minutes through 82 minutes

6 units: ≥ 83 minutes through 97 minutes

7 units: ≥ 98 minutes through 112minutes

8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes. See examples 2 and 3 below.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of timed units billed. See example 1 below.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or

less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes. See example 5 below.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day. See all examples below.

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3B, Documentation Requirements for Therapy Services, indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1 –
24 minutes of neuromuscular reeducation, code 97112, 23 minutes of therapeutic exercise, code 97110,
Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

Example 2 –
20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110), 40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3 –
33 minutes of therapeutic exercise (97110),
7 minutes of manual therapy (97140), 40 Total timed minutes

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –
18 minutes of therapeutic exercise (97110),
13 minutes of manual therapy (97140),
10 minutes of gait training (97116),
8 minutes of ultrasound (97035), 49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5 –

7 minutes of neuromuscular reeducation (97112)
7 minutes therapeutic exercise (97110) 7 minutes manual therapy (97140)
21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub. 100-02, chapter 15, section 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes - including minutes spent providing services represented by untimed codes - are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 220.3.

D. Specific Limits for HCPCS

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called “always therapy” must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

The codes that are allowed one unit for “Allowed Units” in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.

The codes allowed 0 units in the column for “Allowed Units”, may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).

When physicians/NPPs bill “always therapy” codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or

SLP depending on the plan. A physician/NPP shall not bill an “always therapy” code unless the service is provided under a therapy plan of care. Therefore, NA stands for “Not Applicable” in the chart below.

When a “sometimes therapy” code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.

HCPCS	Code Description and Claim Line Outlie r/Edit Details	Timed or Untimed	PT Allowe d units	OT Allowe d units	SLP Allowe d units	Physician/ NPP NOT unde r Therapy POC
92521	Evaluation of speech fluency	Untimed	0	0	1	NA
92522	Evaluation of speech sound production	Untimed	0	0	1	NA
92523	Evaluation of language comprehension and expression	Untimed	0	0	1	NA
92524	Behavioral and qualitative analysis of voice and resonance	Untimed	0	0	1	NA
92597	Oral speech device eval	Untimed	0	1	1	NA
92607	Ex for speech device rx, 1hr	Timed	0	1	1	NA
92611	Motion fluroscopy/swallow	Untimed	0	1	1	1
92612	Endoscope swallow test (fees)	Untimed	0	1	1	1
92614	Laryngoscopic sensory test	Untimed	0	1	1	1
92616	Fees w/laryngeal sense test	Untimed	0	1	1	1
95833	Limb muscle testing, manual	Untimed	1	1	0	1
95834	Limb muscle testing, manual	Untimed	1	1	0	1
96110	Developmental test, lim	Untimed	1	1	1	1
96111	Developmental test, extend	Untimed	1	1	1	1
97001	PT evaluation	Untimed	1	0	0	NA

97002	PT re-evaluation	Untimed	1	0	0	NA
97003	OT evaluation	Untimed	0	1	0	NA

HCPCS	Code Description and Claim Line Outlie r/Edit Details	Timed or Untimed	PT Allowe d units	OT Allowe d units	SLP Allowe d units	Physician/ NPP NOT unde r Therapy POC
97004	OT re-evaluation	Untimed	0	1	0	NA

20.3 - Determining What Time Counts Towards 15-Minute Timed Codes - All Claims (Rev. 1, 10-01-03)

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

20.4 - Coding Guidance for Certain CPT Codes - All Claims (Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The following provides guidance about the use of codes 96105, 97026, 97150, 97545, 97546, and G0128.

- CPT Codes 96105, 97545, and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1- hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is

considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for code 97545 is 2 hours and for code 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the entire time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period of treatment could be coded with another code such as codes 97110, 97112, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the worker's compensation program, thus CMS does not expect to see them reported for Medicare patients except under very unusual circumstances. Further, CMS would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

- CPT Code 97026

Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce a NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries. Further coverage guidelines can be found in the National Coverage Determination Manual (Pub. 100-03), section 270.6.

Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if the claim contains any of the following diagnosis codes:

ICD-9-CM

250.60 - 250.63

354.4, 354.5, 354.9

355.1 - 355.4

355.6 - 355.9

356.0, 356.2-356.4, 356.8-356.9

357.0 - 357.7

674.10, 674.12, 674.14, 674.20, 674.22, 674.24

707.00 -707.07, 707.09-707.15, 707.19

870.0 - 879.9

880.00 - 887.7

890.0 - 897.7

998.31 - 998.32

ICD-10-CM

See Addendum A Chapter 5, Section 20.4 (at end of this chapter) for the list of ICD 10- CM diagnosis codes that require denial with the above HCPCD codes.

Contractors can use the following messages when denying the service:

- Medicare Summary Notice # 21.11 "This service was not covered by Medicare at the time you received it."
- Reason Claim Adjustment Code #50 "These are noncovered services because this is not deemed a medical necessity by the payer."

Advanced Beneficiary Notice (ABN):

Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHA), and hospital outpatient departments are liable if the service is performed, unless the beneficiary signs an ABN.

Similarly, DME suppliers and HHA are liable for the devices when they are supplied, unless the beneficiary signs an ABN.

20.5 - CORF/OPT Edit for Billing Inappropriate Supplies (Rev. 319, Issued: 10-22-04, Effective: 07-01-01, Implementation: 04-04-05)

Supplies furnished by CORFs/OPTs are considered part of the practice expense. Under the Medicare Physician Fee Schedule (MPFS) these expenses are already taken into account in the practice expense relative values. Therefore, CORFs/OPTs should not bill for the supplies

they furnish except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series.

The shared system maintainer will return to CORFs/OPTs any claims that they receive that contain a supply revenue code 270 without the splint and cast Level II HCPCS Q codes and the related Level I applicable HCPCS codes in the 29000 series.

The appropriate Level II HCPCS "Q" codes to be used are Q4001 thru Q4049.

The appropriate Level I HCPCS codes associated with the Level II HCPCS "Q" codes are 29000 thru 29085; 29105 thru 29131; and 29305 thru 29515.

30 - Special Claims Processing Rules for Outpatient Rehabilitation Claims - Form CMS-1500 (Rev. 1, 10-01-03)

Rules for completing a Form CMS-1500 and electronic formats are in Chapter 26. Instructions in §§10.1, 20.1, 20.2, 20.3 and 20.4 above also apply.

30.1 - Determining Payment Amounts (Rev. 1, 10-01-03)

A/B MACs (B) use the MPFS to determine payment for outpatient rehabilitation services. Payment rules are the same as those for other services paid on the MPFS.

Assignment is mandatory.

See chapter 23, for a description of the MPFS.

30.2 - Applicable A/B MAC (B) CWF Type of Service Codes (Rev. 1, 10-01-03)

The A/B MAC (B) assigns the type of service code before submitting the claim record to CWF.

U = Occupational therapy W= Physical therapy

40 - Special Claims Processing Rules for Institutional Outpatient Rehabilitation Claims (Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

40.1 - Determining Payment Amounts – Institutional Claims (Rev. 3367 Issued: 10-07-15, Effective: 01-01-16, Implementation: 01-04-16)

Institutional outpatient rehabilitation claims are paid under the Medicare Physician Fee Schedule (MPFS), except for claims from CAHs and hospitals in Maryland. Medicare contractors should see §100.2 for details on obtaining the correct fee amounts.

40.2 - Applicable Types of Bill (Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation: 10-07-13)

The appropriate types of bill for submitting outpatient rehabilitation services are: 12X, 13X, 22X, 23X, 34X, 74X, 75X, and 85X.

40.3 - Applicable Revenue Codes

(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

The appropriate revenue codes for reporting outpatient rehabilitation services are 0420 - Physical Therapy Services
0430 - Occupational Therapy Services
0440 – Speech-language pathology services

The general classification of revenue codes is all that is needed for billing. If, however, providers choose to use more specific revenue code classifications, the A/B MAC (A) should accept them. Reporting of services is not limited to specific revenue codes; e.g., services other than therapy may be included on the same claim.

Many therapy services may be provided by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS codes in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if a therapist does not deliver the service, then on the type of therapy under the plan of care (POC) for which the service is delivered.

40.4 - Edit Requirements for Revenue Codes

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare contractors edit to assure the presence of a HCPCS code when revenue codes 0420, 0430, 0440, or 0470 are reported. However, Medicare contractors do not edit the matching of revenue code to certain HCPCS codes or edit to limit provider reporting to only those HCPCS listed in section 20.

40.5 - Line Item Date of Service Reporting

(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Implementation: 09-30-10)

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

Contractors will return claims that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting became effective for claims with dates of service on or after October 1, 1998.

Services that do not require line item date of service reporting may be reported before or after those services that require line item reporting.

40.6 - Non-covered Charge Reporting
(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Institutional outpatient therapy claims may report non-covered charges when appropriate according to the instructions provided in of this manual. Outpatient therapies billed as non-covered charges are not counted toward the financial limitation described above, when that limitation is in effect, unless the charges are subject to review after they are submitted and found to be covered by Medicare. Modifiers associated with non-covered charges that are presented in Chapter 1, section 60 can be used on claim lines for therapy services, in addition to the use of modifiers -GN, -GO and -GP.

40.7 - Billing for Biofeedback Training for the Treatment of Urinary Incontinence
(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation: 10-07-13)

Medicare covered biofeedback training for the treatment of urinary incontinence may be provided by physical therapists in facility settings. For information regarding the coverage of this service, see the Medicare National Coverage Determinations Manual, Chapter 1, Section 30.1.1. Medicare pays for this service under the Medicare Physician Fee Schedule.

Providers bill this service on one of the types of bill listed in section 40.2 using revenue code 042X and one of the following HCPCS codes:

- 90901 - Biofeedback training by any modality
- 90911 - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

40.8 – Rebilling Therapy Services for Hospital Inpatients
(Rev. 2868, Issued: 02-06-14, Effective: 07-01-14, Implementation: 07-07-14)

If a beneficiary receives therapy services during an inpatient hospital stay which was denied because the stay was not medically necessary, the therapy services may be rebilled under Medicare Part B coverage. If the therapy would have been reasonable and necessary as hospital outpatient services, and provided the beneficiary has Part B entitlement, the services can be billed using Type of Bill 012x. All payment and billing requirements for outpatient therapy (including therapy caps, functional reporting and other instructions in this chapter) apply to these claims.

50 - CWF and PS&R Requirements - A/B MAC (A)
(Rev. 2044, Issued: 09-03-10, Effective: 09-30-10, Imple mentation: 09-30-10)

The A/B MAC (A) reports the procedure codes in the financial data section (field 65a- 65j) of the PS&R record. It includes revenue code, HCPCS, units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a separate line. The A/B MAC (A) reports the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h "Covered Charges." The PS&R system includes outpatient rehabilitation, and CORF services listed in subsections E and F on a separate report from cost based payments. See the PS&R guidelines for specific information.

100 - Special Rules for Comprehensive Outpatient Rehabilitation Facilities (CORFs)
(Rev. 1, 10-01-03)

100.1 - General
(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Section 933) defines CORFs (Comprehensive Outpatient Rehabilitation Facilities) as a distinct type of Medicare provider and adds CORF services as a benefit under Medicare Part B. The
Balance Budget Act (P.L.105-33) requires payment under a prospective system for all CORF services.

See Chapter 1, for the policy on A/B MAC (A) designations governing CORFs.

See the Medicare Benefit Policy Manual, Chapter 12, for a description of covered CORF services.

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. The physician must bill the area A/B MAC (B) for these services. If they are covered, the A/B MAC (B) reimburses them via the MPFS.

However, other services are considered CORF services to be billed by the CORF to the A/B MAC (A), and are also considered included in the fee amount under the MPFS. These services include such services as administrative services provided by the physician associated with the CORF, examinations for the purpose of establishing and reviewing the plan of care, consultation with and medical supervision of nonphysician staff, team conferences, case reviews, and other facility staff medical and facility administration activities relating to the services described in Medicare Benefit Policy Manual, chapter

12. Related supplies are also included in the MPFS fee amount.

The CORFs bill Medicare with the ASC X12 837 institutional claim or Form CMS-1450 using HCPCS codes and Revenue Codes. Usually the zero level revenue code is used. Payment is based on the HCPCS code and related MPFS amount.

Requirements in §§10 - 50 apply to CORF billing. In addition the following requirements apply.

100.1.1 - Allowable Revenue Codes on CORF 75X Bill Types
(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation: 10-07-13)

Effective October 1, 2012, the following revenue codes are allowable for reporting CORF services on 75X bill types:

0270	0274	0279	029X
0412	0419	042X	0410
044X	0550	0559	043X
0636	0771	0911	0569
0942			

NOTE: Billed revenue codes not listed in the above list will be returned to the provider by Medicare systems. See Chapter 25, Completing and Processing the CMS-1450 Data Set, for revenue code descriptions.

100.2 - Obtaining Fee Schedule Amounts
(Rev. 1, 10-01-03)

The CMS furnishes A/B MACs (A) with an annual therapy abstract file and a CORF supplemental file through the Medicare Telecommunications System. The CMS notifies A/B MACs (A) when new files are available. A/B MACs (A) are responsible for informing CORFs of new fee schedule amounts.

Payment is calculated at 80 percent of the allowed charge after deductible is met. The allowed charge is the lower of billed charges or the fee schedule amount. Unmet deductible is subtracted from the allowed charge, and payment is calculated at 80 percent of the result.

EXAMPLE:

$120 Provider charge;
$100 MPFS amount.

Payment is 80 percent of the lower of the actual charge or fee schedule amount, which in this case is $80.00. ($100.00 (MPFS) X 80 percent.)

The remaining 20 percent or $20 is the patient s coinsurance liability.

These codes are updated as needed by CMS.

If the A/B MAC (A) receives a claim for a Medicare covered CORF service with dates of service on or after July 1, 2000, that does not appear on its fee schedule abstract file, it has two options for obtaining pricing information:

1. It is provided with a therapy abstract file or CORF supplemental file that contains all therapy services and their related prices. This supplemental file contains approximately a million records, and may be used as a resource to extract pricing data as needed. The data in the supplemental file is in the same format as the MPFS abstract file in exhibit 1, but the fields defining the fee and outpatient hospital indicators are not populated, instead they are space-filled.

2. It can contact the local A/B MAC (B) to obtain the price. When requesting the pricing data, it advises the A/B MAC (B) to provide the nonfacility fee from the MPFS. The MPFS supplemental file of physician fee schedule services is available for retrieval through CMS' Mainframe Telecommunications System. The A/B MAC (A) is notified yearly of the file retrieval names and dates by a program memorandum or other communication.

100.3 - Proper Reporting of Nursing Services by CORFs - A/B MAC (A)
(Rev. 1459; Issued: 02-22-08; Effective: 07-01-08; Implementation 07-07-08)

Nursing services performed in the CORF shall be billed utilizing the following HCPCS code:

G0128 – Direct (Face to Face w/ patient) skilled nursing services of a registered nurse provided in a CORF, each 10 minutes beyond the first 5 minutes.

In addition, HCPCS G0128 is billable with revenue codes 0550 and 0559 only.

100.4 - Outpatient Mental Health Treatment Limitation
(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation: 10-07-13)

The Outpatient Mental Health Treatment Limitation (the limitation) is not applicable to CORF services because CORFs do not provide services to treat mental, psychoneurotic and personality disorders that are subject to the limitation in section 1833(c) of the Act. For dates of service on or after October 1, 2012, HCPCS code G0409 is the only code allowed

for social work and psychological services furnished in a CORF. This service is not subject to the limitation because it is not a psychiatric mental health treatment service.

For additional information on the limitation, see Publication 100-01, Chapter 3, section 30 and Publication 100-02, Chapter 12, sections 50-50.5.

100.5 - Off-Site CORF Services

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The CORFs may provide physical therapy, speech-language pathology and occupational therapy off the CORF's premises in addition to the home evaluation. Services provided offsite are billed separately and identified as "offsite" on the claim in remarks. The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

100.6 - Notifying Patient of Service Denial

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Services may be noncovered because they are statutorily excluded from coverage under Medicare, or because they are not medically reasonable and necessary.

If a service is excluded by statute, the CORF may submit a claim for them to Medicare to obtain a denial prior to billing another insurance carrier. It shows the charges as noncovered, and includes Condition Code 21. It may bill the beneficiary for the excluded services, and need not issue an advance beneficiary notice (ABN). However, when providing therapy services under the financial limitations, the CORF should provide the beneficiary with the Notice of Exclusion of Medicare Benefits (NEMB). The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," discusses ABNs for A/B MAC (A) processed claims for Part B services.

If, after reviewing the plan of care, the CORF determines that the services to be furnished to the patient are not medically reasonable or necessary, it immediately provides the beneficiary with an ABN. If the patient signs an ABN, the claim includes occurrence code 32 "Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)" along with the date the ABN was signed.

If the beneficiary insists that a claim be submitted for payment, the CORF must indicate on the bill (billed separately from bills with covered charges) that it is being submitted at the beneficiary's request. This is done by using condition code 20.

If during the course of the patient's treatment the A/B MAC (A) advises the CORF that covered care has ceased, the CORF must notify the beneficiary (or the beneficiary's representative) immediately.

NOTE: Information regarding the form locator numbers that correspond to these data element names is found in Chapter 25.

100.7- Payment of Drugs, Biologicals, and Supplies in a CORF

(Rev. 1459; Issued: 02-22-08; Effective: 07-01-08; Implementation: 07-07-08) Drugs

Drugs and biologicals generally do not apply in a CORF setting. Therefore, contractors are to advise their CORFs not to bill for them.

Supplies

The CORFs should not bill for the supplies they furnish when such supplies are part of the practice expense for that service. Under the MPFS, nearly all of these expenses are already taken into account in the practice expense relative values. However, CORFs may bill separately for certain splint and cast supplies, represented by HCPCS codes Q4001 through Q4051, when furnishing a cast/strapping application service in the CPT code series 29000 through 29750.

Vaccines

The CORFs should refer to Chapter 18, Preventive and Screening Services, for billing guidance on influenza, pneumococcal pneumonia, and Hepatitis B vaccines and their administration.

100.8- Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The CORFs bill DME to the DME MAC with the ASC X12 professional claim format or Form CMS-1500 except for claims for implanted DME, which are billed to the local A/B MAC (B). If the CORF does not have a supplier billing number from the National Supplier Clearinghouse (NSC), it may contact the NSC to secure one. If the local A/B MAC (B) has issued the CORF a provider number for billing physician services, the CORF may not use the same number when billing for DME.

100.10 - Group Therapy Services (Code 97150)
(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01- 29-07)

Policies for group therapy services for CORF are the same as group therapy services for other Part B outpatient services. See Pub 100-02, chapter 15, section 230.

100.10.1 - Therapy Students
(Rev. 1145, Issued: 12-29-06, Effective: 01-01-07, Implementation: on or before 01- 29-07)

Policies for therapy students for CORF are the same as policies for therapy students for other Part B outpatient services. See Pub. 100-02, chapter 15, section 230.

100.11 - Billing for Social Work and Psychological Services in a CORF
(Rev. 2736, Issued: 06-28-13, Effective: 10-01-12, Implementation: 10-07-13)

The CORF providers shall only bill social work and psychological services with the following HCPCS code:

G0409 – Social work and psychological services, directly relating to and/or the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF)

In addition, HCPCS code G0409 shall only be billed with revenue code 0569 or 0911.

100.12 - Billing for Respiratory Therapy Services in a CORF
(Rev. 1459; Issued: 02-22-08; Effective: 07-01-08; Implementation: 07-07-08)

The CORF providers shall only bill respiratory therapy services with revenue codes 0410, 0412 and 0419. See Chapter 25, Completing and Processing the CMS-1450 Data Set, for revenue code descriptions.

Exhibit 1 - Physician Fee Schedule Abstract File
(Rev. 515, Issued: 04-01-05, Effective: 01-03-05, Implementation: 07-05-05)

This file contains nonfacility fee schedule payment amounts for the outpatient rehabilitation, and CORF HCPCS codes listed in §20. These codes are identified in the abstract file by a value of "R" in the fee indicator field. The file includes fee schedule payment amounts by locality and is available via the CMS Mainframe Telecommunications System (formerly referred to as the Network Data Mover).

Record Length: 60
Record Format: FB 6000
Block size: EBCDIC
Character Code: Sort Sequence: A/B MAC (B), Locality HCPCS Code, Modifier

Data Ele ment Name	COBOL Location	Picture	Value
1 – HCPCS	1-5	X(05)	
2 – Modifier	6-7	X(02)	
3 – Filler	8-9	X(02)	

4 -- Non-Facility Fee	10-16	9(05)V99
5 – Filler	17-23	X(07)

Data Element Name	COBOL Location	Picture	Value
6 – Filler	24-30	X(07)	
7 -- A/B MAC (B) Number	31-35	X(05)	
8 – Locality	36-37	X(02)	Identical to the radiology/diagnostic fees
9 – Filler	38-40	X(03)	
10 -- Fee Indicator	41-41	X(1)	"R" - Rehab/Audiology/CORF services
11 -- Outpatient Hospital indicator	42-42	X(1)	"0" - Fee applicable in hospital outpatient setting "1" - Fee not applicable in hospital outpatient setting
12 – Filler	43-60	X(18)	

Upon CMS notification, the contractor is responsible for retrieving this file and making payment based on 80 percent of the lower of the actual charge or fee schedule amount indicated on the file after the Part B deductible has been met. The CMS will notify contractors of updates to the MPFS, file names and when the updated files will be available for retrieval. Upon retrieval, contractors disseminate the fee schedules to their providers. The file is also available on the CMS Web site in the Public Use Files (PUF) area.

Addendum A - Chapter 5, Section 20.4 – Coding Guidance for Certain CPT Codes – All Claims (Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

ICD-10-CM - Code and Description

A52.15 Late syphilitic neuropathy

E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified

E08.41 Diabetes mellitus due to underlying condition with diabetic mononeuropathy

E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy

ICD-10-CM - Code and Description

E09.40 Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified

E09.41 Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy

E09.42 Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy

E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified

E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy

E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy

E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy

E10.44 Type 1 diabetes mellitus with diabetic amyotrophy

E10.49 Type 1 diabetes mellitus with other diabetic neurological complication

E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy

E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified

E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy

E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy

E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy

E11.44 Type 2 diabetes mellitus with diabetic amyotrophy

E11.49 Type 2 diabetes mellitus with other diabetic neurological complication

E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy

E13.40 Other specified diabetes mellitus with diabetic neuropathy, unspecified

E13.41 Other specified diabetes mellitus with diabetic mononeuropathy

E13.42 Other specified diabetes mellitus with diabetic polyneuropathy

E13.43 Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy

E13.44 Other specified diabetes mellitus with diabetic amyotrophy

E13.49 Other specified diabetes mellitus with other diabetic neurological complication

E13.610 Other specified diabetes mellitus with diabetic neuropathic arthropathy

G13.0 Paraneoplastic neuromyopathy and neuropathy

G13.1 Other systemic atrophy primarily affecting central nervous system in neoplastic disease

G56.40 Causalgia of unspecified upper limb

G56.41 Causalgia of right upper limb

G56.42 Causalgia of left upper limb

G56.90 Unspecified mononeuropathy of unspecified upper limb

G56.91 Unspecified mononeuropathy of right upper limb

ICD-10-CM - Code and Description

G56.92 Unspecified mononeuropathy of left upper limb
G57.10 Meralgia paresthetica, unspecified lower limb
G57.11 Meralgia paresthetica, right lower limb
G57.12 Meralgia paresthetica, left lower limb
G57.20 Lesion of femoral nerve, unspecified lower limb
G57.21 Lesion of femoral nerve, right lower limb
G57.22 Lesion of femoral nerve, left lower limb
G57.30 Lesion of lateral popliteal nerve, unspecified lower limb
G57.31 Lesion of lateral popliteal nerve, right lower limb
G57.32 Lesion of lateral popliteal nerve, left lower limb
G57.40 Lesion of medial popliteal nerve, unspecified lower limb
G57.41 Lesion of medial popliteal nerve, right lower limb
G57.42 Lesion of medial popliteal nerve, left lower limb
G57.60 Lesion of plantar nerve, unspecified lower limb
G57.61 Lesion of plantar nerve, right lower limb
G57.62 Lesion of plantar nerve, left lower limb
G57.70 Causalgia of unspecified lower limb
G57.71 Causalgia of right lower limb
G57.72 Causalgia of left lower limb
G57.80 Other specified mononeuropathies of unspecified lower limb
G57.81 Other specified mononeuropathies of right lower limb
G57.82 Other specified mononeuropathies of left lower limb
G57.90 Unspecified mononeuropathy of unspecified lower limb
G57.91 Unspecified mononeuropathy of right lower limb
G57.92 Unspecified mononeuropathy of left lower limb
G58.7 Mononeuritis multiplex
G58.8 Other specified mononeuropathies
G58.9 Mononeuropathy, unspecified
G59 Mononeuropathy in diseases classified elsewhere
G60.0 Hereditary motor and sensory neuropathy
G60.1 Refsum's disease
G60.2 Neuropathy in association with hereditary ataxia
G60.3 Idiopathic progressive neuropathy

G60.8 Other hereditary and idiopathic neuropathies

ICD-10-CM - Code and Description

G60.9 Hereditary and idiopathic neuropathy, unspecified

G61.0 Guillain-Barre syndrome

G61.1 Serum neuropathy

G62.0 Drug-induced polyneuropathy

G62.1 Alcoholic polyneuropathy

G62.2 Polyneuropathy due to other toxic agents

G62.82 Radiation-induced polyneuropathy

G63 Polyneuropathy in diseases classified elsewhere

G65.0 Sequelae of Guilla in-Barré syndrome

G65.1 Sequelae of other inflammatory polyneuropathy

G65.2 Sequelae of toxic polyneuropathy

I70.231 Atherosclerosis of native arteries of right leg with ulceration of thigh

I70.232 Atherosclerosis of native arteries of right leg with ulceration of calf

I70.233 Atherosclerosis of native arteries of right leg with ulceration of ankle

I70.234 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot

I70.235 Atherosclerosis of native arteries of right leg with ulceration of other part of foot

I70.238 Atherosclerosis of native arteries of right leg with ulceration of other part of lower right leg

I70.239 Atherosclerosis of native arteries of right leg with ulceration of unspecified site

I70.241 Atherosclerosis of native arteries of left leg with ulceration of thigh

I70.242 Atherosclerosis of native arteries of left leg with ulceration of calf

I70.243 Atherosclerosis of native arteries of left leg with ulceration of ankle

I70.244 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot

I70.245 Atherosclerosis of native arteries of left leg with ulceration of other part of foot

I70.248 Atherosclerosis of native arteries of left leg with ulceration of other part of lower left leg

I70.249 Atherosclerosis of native arteries of left leg with ulceration of unspecified site

I70.331 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of thigh

I70.332 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of calf

I70.333 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of ankle

I70.334 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of heel and midfoot

ICD-10-CM - Code and Description

I70.335 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of foot

I70.338 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.339 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of unspecified site

I70.341 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of thigh

I70.342 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of calf

I70.343 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of ankle

I70.344 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.345 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of foot

I70.348 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.349 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of unspecified site

I70.431 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of thigh

I70.432 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of calf

I70.433 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle

I70.434 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.435 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of foot

I70.438 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.439 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of unspecified site

I70.441 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of thigh

I70.442 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of calf

ICD-10-CM - Code and Description

I70.443 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle

I70.444 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.445 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of foot

I70.448 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.449 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of unspecified site

I70.531 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of thigh

I70.532 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of calf

I70.533 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle

I70.534 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.535 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of foot

I70.538 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.539 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of unspecified site

I70.541 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of thigh

I70.542 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of calf

I70.543 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of ankle

I70.544 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.545 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of foot

I70.548 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.549 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of unspecified site

ICD-10-CM - Code and Description

I70.631 Atherosclerosis of nonbiologica l bypass graft(s) of the right leg with ulceration of thigh

I70.632 Atherosclerosis of nonbiologica l bypass graft(s) of the right leg with ulceration of calf

I70.633 Atherosclerosis of nonbiologica l bypass graft(s) of the right leg with ulceration of ankle

I70.634 Atherosclerosis of nonbiologica l bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.635 Atherosclerosis of nonbiologica l bypass graft(s) of the right leg with ulceration of other part of foot

I70.638 Atherosclerosis of nonbiologica l bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.639 Atherosclerosis of nonbiologica l bypass graft(s) of the right leg with ulceration of unspecified site

I70.641 Atherosclerosis of nonbiologica l bypass graft(s) of the left leg with ulceration of thigh

I70.642 Atherosclerosis of nonbiologica l bypass graft(s) of the left leg with ulceration of calf

I70.643 Atherosclerosis of nonbiologica l bypass graft(s) of the left leg with ulceration of ankle

I70.644 Atherosclerosis of nonbiologica l bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.645 Atherosclerosis of nonbiologica l bypass graft(s) of the left leg with ulceration of other part of foot

I70.648 Atherosclerosis of nonbiologica l bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.649 Atherosclerosis of nonbiologica l bypass graft(s) of the left leg with ulceration of unspecified site

I70.731 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of thigh

I70.732 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of calf

I70.733 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of ankle

I70.734 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.735 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of foot

ICD-10-CM - Code and Description

I70.738 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.739 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of unspecified site

I70.741 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of thigh

I70.742 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of calf

I70.743 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of ankle

I70.744 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.745 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of foot

I70.748 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.749 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of unspecified site

L89.000 Pressure ulcer of unspecified elbow, unstageable

L89.001 Pressure ulcer of unspecified elbow, stage 1

L89.002 Pressure ulcer of unspecified elbow, stage 2

L89.003 Pressure ulcer of unspecified elbow, stage 3

L89.004 Pressure ulcer of unspecified elbow, stage 4

L89.009 Pressure ulcer of unspecified elbow, unspecified stage

L89.010 Pressure ulcer of right elbow, unstageable

L89.011 Pressure ulcer of right elbow, stage 1

L89.012 Pressure ulcer of right elbow, stage 2

L89.013 Pressure ulcer of right elbow, stage 3

L89.014 Pressure ulcer of right elbow, stage 4

L89.019 Pressure ulcer of right elbow, unspecified stage

L89.020 Pressure ulcer of left elbow, unstageable

L89.021 Pressure ulcer of left elbow, stage 1

L89.022 Pressure ulcer of left elbow, stage 2

L89.023 Pressure ulcer of left elbow, stage 3

L89.024 Pressure ulcer of left elbow, stage 4

L89.029 Pressure ulcer of left elbow, unspecified stage

ICD-10-CM - Code and Description

L89.100 Pressure ulcer of unspecified part of back, unstageable
L89.101 Pressure ulcer of unspecified part of back, stage 1
L89.102 Pressure ulcer of unspecified part of back, stage 2
L89.103 Pressure ulcer of unspecified part of back, stage 3
L89.104 Pressure ulcer of unspecified part of back, stage 4
L89.109 Pressure ulcer of unspecified part of back, unspecified stage
L89.110 Pressure ulcer of right upper back, unstageable
L89.111 Pressure ulcer of right upper back, stage 1
L89.112 Pressure ulcer of right upper back, stage 2
L89.113 Pressure ulcer of right upper back, stage 3
L89.114 Pressure ulcer of right upper back, stage 4
L89.119 Pressure ulcer of right upper back, unspecified stage
L89.120 Pressure ulcer of left upper back, unstageable
L89.121 Pressure ulcer of left upper back, stage 1
L89.122 Pressure ulcer of left upper back, stage 2
L89.123 Pressure ulcer of left upper back, stage 3
L89.124 Pressure ulcer of left upper back, stage 4
L89.129 Pressure ulcer of left upper back, unspecified stage
L89.130 Pressure ulcer of right lower back, unstageable
L89.131 Pressure ulcer of right lower back, stage 1
L89.132 Pressure ulcer of right lower back, stage 2
L89.133 Pressure ulcer of right lower back, stage 3
L89.134 Pressure ulcer of right lower back, stage 4
L89.139 Pressure ulcer of right lower back, unspecified stage
L89.140 Pressure ulcer of left lower back, unstageable
L89.141 Pressure ulcer of left lower back, stage 1
L89.142 Pressure ulcer of left lower back, stage 2
L89.143 Pressure ulcer of left lower back, stage 3
L89.144 Pressure ulcer of left lower back, stage 4
L89.149 Pressure ulcer of left lower back, unspecified stage
L89.150 Pressure ulcer of sacral region, unstageable
L89.151 Pressure ulcer of sacral region, stage 1
L89.152 Pressure ulcer of sacral region, stage 2

L89.153 Pressure ulcer of sacral region, stage 3

ICD-10-CM - Code and Description

L89.154 Pressure ulcer of sacral region, stage 4
L89.159 Pressure ulcer of sacral region, unspecified stage
L89.200 Pressure ulcer of unspecified hip, unstageable
L89.201 Pressure ulcer of unspecified hip, stage 1
L89.202 Pressure ulcer of unspecified hip, stage 2
L89.203 Pressure ulcer of unspecified hip, stage 3
L89.204 Pressure ulcer of unspecified hip, stage 4
L89.209 Pressure ulcer of unspecified hip, unspecified stage
L89.210 Pressure ulcer of right hip, unstageable
L89.211 Pressure ulcer of right hip, stage 1
L89.212 Pressure ulcer of right hip, stage 2
L89.213 Pressure ulcer of right hip, stage 3
L89.214 Pressure ulcer of right hip, stage 4
L89.219 Pressure ulcer of right hip, unspecified stage
L89.220 Pressure ulcer of left hip, unstageable
L89.221 Pressure ulcer of left hip, stage 1
L89.222 Pressure ulcer of left hip, stage 2
L89.223 Pressure ulcer of left hip, stage 3
L89.224 Pressure ulcer of left hip, stage 4
L89.229 Pressure ulcer of left hip, unspecified stage
L89.300 Pressure ulcer of unspecified buttock, unstageable
L89.301 Pressure ulcer of unspecified buttock, stage 1
L89.302 Pressure ulcer of unspecified buttock, stage 2
L89.303 Pressure ulcer of unspecified buttock, stage 3
L89.304 Pressure ulcer of unspecified buttock, stage 4
L89.309 Pressure ulcer of unspecified buttock, unspecified stage
L89.310 Pressure ulcer of right buttock, unstageable
L89.311 Pressure ulcer of right buttock, stage 1
L89.312 Pressure ulcer of right buttock, stage 2
L89.313 Pressure ulcer of right buttock, stage 3
L89.314 Pressure ulcer of right buttock, stage 4
L89.319 Pressure ulcer of right buttock, unspecified stage
L89.320 Pressure ulcer of left buttock, unstageable

L89.321 Pressure ulcer of left buttock, stage 1

ICD-10-CM - Code and Description

L89.322 Pressure ulcer of left buttock, stage 2
L89.323 Pressure ulcer of left buttock, stage 3
L89.324 Pressure ulcer of left buttock, stage 4
L89.329 Pressure ulcer of left buttock, unspecified stage
L89.40 Pressure ulcer of contiguous site of back, buttock and hip, unspecified stage
L89.41 Pressure ulcer of contiguous site of back, buttock and hip, stage 1
L89.42 Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43 Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44 Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45 Pressure ulcer of contiguous site of back, buttock and hip, unstageable
L89.500 Pressure ulcer of unspecified ankle, unstageable
L89.501 Pressure ulcer of unspecified ankle, stage 1
L89.502 Pressure ulcer of unspecified ankle, stage 2
L89.503 Pressure ulcer of unspecified ankle, stage 3
L89.504 Pressure ulcer of unspecified ankle, stage 4
L89.509 Pressure ulcer of unspecified ankle, unspecified stage
L89.510 Pressure ulcer of right ankle, unstageable
L89.511 Pressure ulcer of right ankle, stage 1
L89.512 Pressure ulcer of right ankle, stage 2
L89.513 Pressure ulcer of right ankle, stage 3
L89.514 Pressure ulcer of right ankle, stage 4
L89.519 Pressure ulcer of right ankle, unspecified stage
L89.520 Pressure ulcer of left ankle, unstageable
L89.521 Pressure ulcer of left ankle, stage 1
L89.522 Pressure ulcer of left ankle, stage 2
L89.523 Pressure ulcer of left ankle, stage 3
L89.524 Pressure ulcer of left ankle, stage 4
L89.529 Pressure ulcer of left ankle, unspecified stage
L89.600 Pressure ulcer of unspecified heel, unstageable
L89.601 Pressure ulcer of unspecified heel, stage 1
L89.602 Pressure ulcer of unspecified heel, stage 2
L89.603 Pressure ulcer of unspecified heel, stage 3
L89.604 Pressure ulcer of unspecified heel, stage 4

L89.609 Pressure ulcer of unspecified heel, unspecified stage

ICD-10-CM - Code and Description

L89.610 Pressure ulcer of right heel, unstageable
L89.611 Pressure ulcer of right heel, stage 1
L89.612 Pressure ulcer of right heel, stage 2
L89.613 Pressure ulcer of right heel, stage 3
L89.614 Pressure ulcer of right heel, stage 4
L89.619 Pressure ulcer of right heel, unspecified stage
L89.620 Pressure ulcer of left heel, unstageable
L89.621 Pressure ulcer of left heel, stage 1
L89.622 Pressure ulcer of left heel, stage 2
L89.623 Pressure ulcer of left heel, stage 3
L89.624 Pressure ulcer of left heel, stage 4
L89.629 Pressure ulcer of left heel, unspecified stage
L89.810 Pressure ulcer of head, unstageable
L89.811 Pressure ulcer of head, stage 1
L89.812 Pressure ulcer of head, stage 2
L89.813 Pressure ulcer of head, stage 3
L89.814 Pressure ulcer of head, stage 4
L89.819 Pressure ulcer of head, unspecified stage
L89.890 Pressure ulcer of other site, unstageable
L89.891 Pressure ulcer of other site, stage 1
L89.892 Pressure ulcer of other site, stage 2
L89.893 Pressure ulcer of other site, stage 3
L89.894 Pressure ulcer of other site, stage 4
L89.899 Pressure ulcer of other site, unspecified stage
L89.90 Pressure ulcer of unspecified site, unspecified stage
L89.91 Pressure ulcer of unspecified site, stage 1
L89.92 Pressure ulcer of unspecified site, stage 2
L89.93 Pressure ulcer of unspecified site, stage 3
L89.94 Pressure ulcer of unspecified site, stage 4
L89.95 Pressure ulcer of unspecified site, unstageable
L97.101 Non-pressure chronic ulcer of unspecified thigh limited to breakdown of skin
L97.102 Non-pressure chronic ulcer of unspecified thigh with fat layer exposed
L97.103 Non-pressure chronic ulcer of unspecified thigh with necrosis of muscle

L97.104 Non-pressure chronic ulcer of unspecified thigh with necrosis of bone

ICD-10-CM - Code and Description

L97.109 Non-pressure chronic ulcer of unspecified thigh with unspecified severity
L97.111 Non-pressure chronic ulcer of right thigh limited to breakdown of skin
L97.112 Non-pressure chronic ulcer of right thigh with fat layer exposed
L97.113 Non-pressure chronic ulcer of right thigh with necrosis of muscle
L97.114 Non-pressure chronic ulcer of right thigh with necrosis of bone
L97.119 Non-pressure chronic ulcer of right thigh with unspecified severity
L97.121 Non-pressure chronic ulcer of left thigh limited to breakdown of skin
L97.122 Non-pressure chronic ulcer of left thigh with fat layer exposed
L97.123 Non-pressure chronic ulcer of left thigh with necrosis of muscle
L97.124 Non-pressure chronic ulcer of left thigh with necrosis of bone
L97.129 Non-pressure chronic ulcer of left thigh with unspecified severity
L97.201 Non-pressure chronic ulcer of unspecified calf limited to breakdown of skin
L97.202 Non-pressure chronic ulcer of unspecified calf with fat layer exposed
L97.203 Non-pressure chronic ulcer of unspecified calf with necrosis of muscle
L97.204 Non-pressure chronic ulcer of unspecified calf with necrosis of bone
L97.209 Non-pressure chronic ulcer of unspecified calf with unspecified severity
L97.211 Non-pressure chronic ulcer of right calf limited to breakdown of skin
L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed
L97.213 Non-pressure chronic ulcer of right calf with necrosis of muscle
L97.214 Non-pressure chronic ulcer of right calf with necrosis of bone
L97.219 Non-pressure chronic ulcer of right calf with unspecified severity
L97.221 Non-pressure chronic ulcer of left calf limited to breakdown of skin
L97.222 Non-pressure chronic ulcer of left calf with fat layer exposed
L97.223 Non-pressure chronic ulcer of left calf with necrosis of muscle
L97.224 Non-pressure chronic ulcer of left calf with necrosis of bone
L97.229 Non-pressure chronic ulcer of left calf with unspecified severity
L97.301 Non-pressure chronic ulcer of unspecified ankle limited to breakdown of skin
L97.302 Non-pressure chronic ulcer of unspecified ankle with fat layer exposed
L97.303 Non-pressure chronic ulcer of unspecified ankle with necrosis of muscle
L97.304 Non-pressure chronic ulcer of unspecified ankle with necrosis of bone
L97.309 Non-pressure chronic ulcer of unspecified ankle with unspecified severity
L97.311 Non-pressure chronic ulcer of right ankle limited to breakdown of skin
L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed

L97.313 Non-pressure chronic ulcer of right ankle with necrosis of muscle

ICD-10-CM - Code and Description

L97.314 Non-pressure chronic ulcer of right ankle with necrosis of bone

L97.319 Non-pressure chronic ulcer of right ankle with unspecified severity

L97.321 Non-pressure chronic ulcer of left ankle limited to breakdown of skin

L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed

L97.323 Non-pressure chronic ulcer of left ankle with necrosis of muscle

L97.324 Non-pressure chronic ulcer of left ankle with necrosis of bone

L97.329 Non-pressure chronic ulcer of left ankle with unspecified severity

L97.401 Non-pressure chronic ulcer of unspecified heel and midfoot limited to breakdown of skin

L97.402 Non-pressure chronic ulcer of unspecified heel and midfoot with fat layer exposed

L97.403 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of muscle

L97.404 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of bone

L97.409 Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity

L97.411 Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin

L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed

L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle

L97.414 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone

L97.419 Non-pressure chronic ulcer of right heel and midfoot with unspecified severity

L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin

L97.422 Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed

L97.423 Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle

L97.424 Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone

L97.429 Non-pressure chronic ulcer of left heel and midfoot with unspecified severity

L97.501 Non-pressure chronic ulcer of other part of unspecified foot limited to breakdown of skin

L97.502 Non-pressure chronic ulcer of other part of unspecified foot with fat layer exposed

L97.503 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of muscle

L97.504 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of bone

ICD-10-CM - Code and Description

L97.509 Non-pressure chronic ulcer of other part of unspecified foot with unspecified severity

L97.511 Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin

L97.512 Non-pressure chronic ulcer of other part of right foot with fat layer exposed

L97.513 Non-pressure chronic ulcer of other part of right foot with necrosis of muscle

L97.514 Non-pressure chronic ulcer of other part of right foot with necrosis of bone

L97.519 Non-pressure chronic ulcer of other part of right foot with unspecified severity

L97.521 Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin

L97.522 Non-pressure chronic ulcer of other part of left foot with fat layer exposed

L97.523 Non-pressure chronic ulcer of other part of left foot with necrosis of muscle

L97.524 Non-pressure chronic ulcer of other part of left foot with necrosis of bone

L97.529 Non-pressure chronic ulcer of other part of left foot with unspecified severity

L97.801 Non-pressure chronic ulcer of other part of unspecified lower leg limited to breakdown of skin

L97.802 Non-pressure chronic ulcer of other part of unspecified lower leg with fat layer exposed

L97.803 Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of muscle

L97.804 Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of bone

L97.809 Non-pressure chronic ulcer of other part of unspecified lower leg with unspecified severity

L97.811 Non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin

L97.812 Non-pressure chronic ulcer of other part of right lower leg with fat layer exposed

L97.813 Non-pressure chronic ulcer of other part of right lower leg with necrosis of muscle

L97.814 Non-pressure chronic ulcer of other part of right lower leg with necrosis of bone

L97.819 Non-pressure chronic ulcer of other part of right lower leg with unspecified severity

L97.821 Non-pressure chronic ulcer of other part of left lower leg limited to breakdown of skin

L97.822 Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed

ICD-10-CM - Code and Description

L97.823 Non-pressure chronic ulcer of other part of left lower leg with necrosis of muscle

L97.824 Non-pressure chronic ulcer of other part of left lower leg with necrosis of bone

L97.829 Non-pressure chronic ulcer of other part of left lower leg with unspecified severity

L97.901 Non-pressure chronic ulcer of unspecified part of unspecified lower leg limited to breakdown of skin

L97.902 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with fat layer exposed

L97.903 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with necrosis of muscle

L97.904 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with necrosis of bone

L97.909 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity

L97.911 Non-pressure chronic ulcer of unspecified part of right lower leg limited to breakdown of skin

L97.912 Non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed

L97.913 Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of muscle

L97.914 Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of bone

L97.919 Non-pressure chronic ulcer of unspecified part of right lower leg with unspecified severity

L97.921 Non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin

L97.922 Non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed

L97.923 Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of muscle

L97.924 Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of bone

L97.929 Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity

M05.50 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site

M05.511 Rheumatoid polyneuropathy with rheumatoid arthritis of right shoulder

M05.512 Rheumatoid polyneuropathy with rheumatoid arthritis of left shoulder

ICD-10-CM - Code and Description

M05.519 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified shoulder

M05.521 Rheumatoid polyneuropathy with rheumatoid arthritis of right elbow

M05.522 Rheumatoid polyneuropathy with rheumatoid arthritis of left elbow

M05.529 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified elbow

M05.531 Rheumatoid polyneuropathy with rheumatoid arthritis of right wrist

M05.532 Rheumatoid polyneuropathy with rheumatoid arthritis of left wrist

M05.539 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified wrist

M05.541 Rheumatoid polyneuropathy with rheumatoid arthritis of right hand

M05.542 Rheumatoid polyneuropathy with rheumatoid arthritis of left hand

M05.549 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hand

M05.551 Rheumatoid polyneuropathy with rheumatoid arthritis of right hip

M05.552 Rheumatoid polyneuropathy with rheumatoid arthritis of left hip

M05.559 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hip

M05.561 Rheumatoid polyneuropathy with rheumatoid arthritis of right knee

M05.562 Rheumatoid polyneuropathy with rheumatoid arthritis of left knee

M05.569 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee

M05.571 Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot

M05.572 Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot

M05.579 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified ankle and foot

M05.59 Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites

M34.83 Systemic sclerosis with polyneuropathy

O90.0 Disruption of cesarean delivery wound

O90.1 Disruption of perineal obstetric wound

S01.00XA Unspecified open wound of scalp, initial encounter

S01.01XA Laceration without foreign body of scalp, initial encounter

S01.02XA Laceration with foreign body of scalp, initial encounter

S01.03XA Puncture wound without foreign body of scalp, initial encounter

S01.04XA Puncture wound with foreign body of scalp, initial encounter

S01.05XA Open bite of scalp, initial encounter

S01.101A Unspecified open wound of right eyelid and periocular area, initial encounter

S01.102A Unspecified open wound of left eyelid and periocular area, initial encounter

S01.109A Unspecified open wound of unspecified eyelid and periocular area, initial encounter

ICD-10-CM - Code and Description

S01.111A Laceration without foreign body of right eyelid and periocular area, initial encounter

S01.112A Laceration without foreign body of left eyelid and periocular area, initial encounter

S01.119A Laceration without foreign body of unspecified eyelid and periocular area, initial encounter

S01.119A Laceration without foreign body of unspecified eyelid and periocular area, initial encounter

S01.121A Laceration with foreign body of right eyelid and periocular area, initial encounter

S01.122A Laceration with foreign body of left eyelid and periocular area, initial encounter

S01.129A Laceration with foreign body of unspecified eyelid and periocular area, initial encounter

S01.129A Laceration with foreign body of unspecified eyelid and periocular area, initial encounter

S01.131A Puncture wound without foreign body of right eyelid and periocular area, initial encounter

S01.132A Puncture wound without foreign body of left eyelid and periocular area, initial encounter

S01.139A Puncture wound without foreign body of unspecified eyelid and periocular area, initial encounter

S01.141A Puncture wound with foreign body of right eyelid and periocular area, initial encounter

S01.142A Puncture wound with foreign body of left eyelid and periocular area, initial encounter

S01.149A Puncture wound with foreign body of unspecified eyelid and periocular area, initial encounter

S01.151A Open bite of right eyelid and periocular area, initial encounter

S01.152A Open bite of left eyelid and periocular area, initial encounter

S01.159A Open bite of unspecified eyelid and periocular area, initial encounter

S01.20XA Unspecified open wound of nose, initial encounter

S01.21XA Laceration without foreign body of nose, initial encounter

S01.22XA Laceration with foreign body of nose, initial encounter

S01.23XA Puncture wound without foreign body of nose, initial encounter

S01.24XA Puncture wound with foreign body of nose, initial encounter

S01.25XA Open bite of nose, initial encounter

S01.301A Unspecified open wound of right ear, initial encounter

ICD-10-CM - Code and Description

S01.302A Unspecified open wound of left ear, initial encounter

S01.309A Unspecified open wound of unspecified ear, initial encounter

S01.311A Laceration without foreign body of right ear, initial encounter

S01.312A Laceration without foreign body of left ear, initial encounter

S01.319A Laceration without foreign body of unspecified ear, initial encounter

S01.321A Laceration with foreign body of right ear, initial encounter

S01.322A Laceration with foreign body of left ear, initial encounter

S01.329A Laceration with foreign body of unspecified ear, initial encounter

S01.331A Puncture wound without foreign body of right ear, initial encounter

S01.332A Puncture wound without foreign body of left ear, initial encounter

S01.339A Puncture wound without foreign body of unspecified ear, initial encounter

S01.341A Puncture wound with foreign body of right ear, initial encounter

S01.342A Puncture wound with foreign body of left ear, initial encounter

S01.349A Puncture wound with foreign body of unspecified ear, initial encounter

S01.351A Open bite of right ear, initial encounter

S01.352A Open bite of left ear, initial encounter

S01.359A Open bite of unspecified ear, initial encounter

S01.401A Unspecified open wound of right cheek and temporomandibular area, initial encounter

S01.402A Unspecified open wound of left cheek and temporomandibular area, initial encounter

S01.409A Unspecified open wound of unspecified cheek and temporomandibular area, initial encounter

S01.411A Laceration without foreign body of right cheek and temporomandibular area, initial encounter

S01.412A Laceration without foreign body of left cheek and temporomandibular area, initial encounter

S01.419A Laceration without foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.421A Laceration with foreign body of right cheek and temporomandibular area, initial encounter

S01.422A Laceration with foreign body of left cheek and temporomandibular area, initial encounter

S01.429A Laceration with foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.431A Puncture wound without foreign body of right cheek and temporomandibular area, initial encounter

ICD-10-CM - Code and Description

S01.432A Puncture wound without foreign body of left cheek and temporomandibular area, initial encounter

S01.439A Puncture wound without foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.441A Puncture wound with foreign body of right cheek and temporomandibular area, initial encounter

S01.442A Puncture wound with foreign body of left cheek and temporomandibular area, initial encounter

S01.449A Puncture wound with foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.451A Open bite of right cheek and temporomandibular area, initial encounter

S01.452A Open bite of left cheek and temporomandibular area, initial encounter

S01.459A Open bite of unspecified cheek and temporomandibular area, initial encounter

S01.501A Unspecified open wound of lip, initial encounter

S01.502A Unspecified open wound of oral cavity, initial encounter

S01.511A Laceration without foreign body of lip, initial encounter

S01.512A Laceration without foreign body of oral cavity, initial encounter

S01.521A Laceration with foreign body of lip, initial encounter

S01.522A Laceration with foreign body of oral cavity, initial encounter

S01.531A Puncture wound without foreign body of lip, initial encounter

S01.532A Puncture wound without foreign body of oral cavity, initial encounter

S01.541A Puncture wound with foreign body of lip, initial encounter

S01.542A Puncture wound with foreign body of oral cavity, initial encounter

S01.551A Open bite of lip, initial encounter

S01.552A Open bite of oral cavity, initial encounter

S01.80XA Unspecified open wound of other part of head, initial encounter

S01.81XA Laceration without foreign body of other part of head, initial encounter

S01.82XA Laceration with foreign body of other part of head, initial encounter

S01.83XA Puncture wound without foreign body of other part of head, initial encounter

S01.84XA Puncture wound with foreign body of other part of head, initial encounter

S01.85XA Open bite of other part of head, initial encounter

S01.90XA Unspecified open wound of unspecified part of head, initial encounter

S01.91XA Laceration without foreign body of unspecified part of head, initial encounter

S01.92XA Laceration with foreign body of unspecified part of head, initial encounter

S01.93XA Puncture wound without foreign body of unspecified part of head, initial encounter

ICD-10-CM - Code and Description

S01.94XA Puncture wound with foreign body of unspecified part of head, initial encounter

S01.95XA Open bite of unspecified part of head, initial encounter

S02.5XXA Fracture of tooth (traumatic), initial encounter for closed fracture

S02.5XXB Fracture of tooth (traumatic), initial encounter for open fracture

S03.2XXA Dislocation of tooth, initial encounter

S05.20XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, unspecified eye, initial encounter

S05.21XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, right eye, initial encounter

S05.22XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, left eye, initial encounter

S05.30XA Ocular laceration without prolapse or loss of intraocular tissue, unspecified eye, initial encounter

S05.31XA Ocular laceration without prolapse or loss of intraocular tissue, right eye, initial encounter

S05.32XA Ocular laceration without prolapse or loss of intraocular tissue, left eye, initial encounter

S05.40XA Penetrating wound of orbit with or without foreign body, unspecified eye, initial encounter

S05.41XA Penetrating wound of orbit with or without foreign body, right eye, initial encounter

S05.42XA Penetrating wound of orbit with or without foreign body, left eye, initial encounter

S05.50XA Penetrating wound with foreign body of unspecified eyeball, initial encounter

S05.51XA Penetrating wound with foreign body of right eyeball, initial encounter

S05.52XA Penetrating wound with foreign body of left eyeball, initial encounter

S05.60XA Penetrating wound without foreign body of unspecified eyeball, initial encounter

S05.61XA Penetrating wound without foreign body of right eyeball, initial encounter

S05.62XA Penetrating wound without foreign body of left eyeball, initial encounter

S05.70XA Avulsion of unspecified eye, initial encounter

S05.71XA Avulsion of right eye, initial encounter

S05.72XA Avulsion of left eye, initial encounter

S05.8X1A Other injuries of right eye and orbit, initial encounter

S05.8X2A Other injuries of left eye and orbit, initial encounter

S05.8X9A Other injuries of unspecified eye and orbit, initial encounter

ICD-10-CM - Code and Description

S05.90XA Unspecified injury of unspecified eye and orbit, initial encounter
S05.91XA Unspecified injury of right eye and orbit, initial encounter
S05.92XA Unspecified injury of left eye and orbit, initial encounter
S08.0XXA Avulsion of scalp, initial encounter
S08.111A Complete traumatic amputation of right ear, initial encounter
S08.112A Complete traumatic amputation of left ear, initial encounter
S08.119A Complete traumatic amputation of unspecified ear, initial encounter
S08.121A Partial traumatic amputation of right ear, initial encounter
S08.122A Partial traumatic amputation of left ear, initial encounter
S08.129A Partial traumatic amputation of unspecified ear, initial encounter
S08.811A Complete traumatic amputation of nose, initial encounter
S08.812A Partial traumatic amputation of nose, initial encounter
S08.89XA Traumatic amputation of other parts of head, initial encounter
S09.12XA Laceration of muscle and tendon of head, initial encounter
S09.20XA Traumatic rupture of unspecified ear drum, initial encounter
S09.21XA Traumatic rupture of right ear drum, initial encounter
S09.22XA Traumatic rupture of left ear drum, initial encounter
S09.301A Unspecified injury of right middle and inner ear, initial encounter
S09.302A Unspecified injury of left middle and inner ear, initial encounter
S09.309A Unspecified injury of unspecified middle and inner ear, initial encounter
S09.311A Primary blast injury of right ear, initial encounter
S09.312A Primary blast injury of left ear, initial encounter
S09.313A Primary blast injury of ear, bilateral, initial encounter
S09.319A Primary blast injury of unspecified ear, initial encounter
S09.391A Other specified injury of right middle and inner ear, initial encounter
S09.392A Other specified injury of left middle and inner ear, initial encounter
S09.399A Other specified injury of unspecified middle and inner ear, initial encounter
S09.8XXA Other specified injuries of head, initial encounter
S09.90XA Unspecified injury of head, initial encounter
S09.91XA Unspecified injury of ear, initial encounter
S09.93XA Unspecified injury of face, initial encounter
S11.011A Laceration without foreign body of larynx, initial encounter
S11.012A Laceration with foreign body of larynx, initial encounter

S11.013A Puncture wound without foreign body of larynx, initial encounter

ICD-10-CM - Code and Description

S11.014A Puncture wound with foreign body of larynx, initial encounter

S11.015A Open bite of larynx, initial encounter

S11.019A Unspecified open wound of larynx, initial encounter

S11.021A Laceration without foreign body of trachea, initial encounter

S11.022A Laceration with foreign body of trachea, initial encounter

S11.023A Puncture wound without foreign body of trachea, initial encounter

S11.024A Puncture wound with foreign body of trachea, initial encounter

S11.025A Open bite of trachea, initial encounter

S11.029A Unspecified open wound of trachea, initial encounter

S11.031A Laceration without foreign body of vocal cord, initial encounter

S11.032A Laceration with foreign body of vocal cord, initial encounter

S11.033A Puncture wound without foreign body of vocal cord, initial encounter

S11.034A Puncture wound with foreign body of vocal cord, initial encounter

S11.035A Open bite of vocal cord, initial encounter

S11.039A Unspecified open wound of vocal cord, initial encounter

S11.10XA Unspecified open wound of thyroid gland, initial encounter

S11.11XA Laceration without foreign body of thyroid gland, initial encounter

S11.12XA Laceration with foreign body of thyroid gland, initial encounter

S11.13XA Puncture wound without foreign body of thyroid gland, initial encounter

S11.14XA Puncture wound with foreign body of thyroid gland, initial encounter

S11.15XA Open bite of thyroid gland, initial encounter

S11.20XA Unspecified open wound of pharynx and cervical esophagus, initial encounter

S11.21XA Laceration without foreign body of pharynx and cervical esophagus, initial encounter

S11.22XA Laceration with foreign body of pharynx and cervical esophagus, initial encounter

S11.23XA Puncture wound without foreign body of pharynx and cervical esophagus, initial encounter

S11.24XA Puncture wound with foreign body of pharynx and cervical esophagus, initial encounter

S11.25XA Open bite of pharynx and cervical esophagus, initial encounter

S11.80XA Unspecified open wound of other specified part of neck, initial encounter

S11.81XA Laceration without foreign body of other specified part of neck, initial encounter

S11.82XA Laceration with foreign body of other specified part of neck, initial encounter

ICD-10-CM - Code and Description

S11.83XA Puncture wound without foreign body of other specified part of neck, initial encounter

S11.84XA Puncture wound with foreign body of other specified part of neck, initial encounter

S11.85XA Open bite of other specified part of neck, initial encounter

S11.89XA Other open wound of other specified part of neck, initial encounter

S11.90XA Unspecified open wound of unspecified part of neck, initial encounter

S11.91XA Laceration without foreign body of unspecified part of neck, initial encounter

S11.92XA Laceration with foreign body of unspecified part of neck, initial encounter

S11.93XA Puncture wound without foreign body of unspecified part of neck, initial encounter

S11.94XA Puncture wound with foreign body of unspecified part of neck, initial encounter

S11.95XA Open bite of unspecified part of neck, initial encounter

S16.2XXA Laceration of muscle, fascia and tendon at neck level, initial encounter

S21.001A Unspecified open wound of right breast, initial encounter

S21.002A Unspecified open wound of left breast, initial encounter

S21.009A Unspecified open wound of unspecified breast, initial encounter

S21.011A Laceration without foreign body of right breast, initial encounter

S21.012A Laceration without foreign body of left breast, initial encounter

S21.019A Laceration without foreign body of unspecified breast, initial encounter

S21.021A Laceration with foreign body of right breast, initial encounter

S21.022A Laceration with foreign body of left breast, initial encounter

S21.029A Laceration with foreign body of unspecified breast, initial encounter

S21.031A Puncture wound without foreign body of right breast, initial encounter

S21.032A Puncture wound without foreign body of left breast, initial encounter

S21.039A Puncture wound without foreign body of unspecified breast, initial encounter

S21.041A Puncture wound with foreign body of right breast, initial encounter

S21.042A Puncture wound with foreign body of left breast, initial encounter

S21.049A Puncture wound with foreign body of unspecified breast, initial encounter

S21.051A Open bite of right breast, initial encounter

S21.052A Open bite of left breast, initial encounter

S21.059A Open bite of unspecified breast, initial encounter

S21.101A Unspecified open wound of right front wall of thorax without penetration into thoracic cavity, initial encounter

ICD-10-CM - Code and Description

S21.102A Unspecified open wound of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.109A Unspecified open wound of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.111A Laceration without foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.112A Laceration without foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.119A Laceration without foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.121A Laceration with foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.122A Laceration with foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.129A Laceration with foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.131A Puncture wound without foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.132A Puncture wound without foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.139A Puncture wound without foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.141A Puncture wound with foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.142A Puncture wound with foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.149A Puncture wound with foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.151A Open bite of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.152A Open bite of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.159A Open bite of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.201A Unspecified open wound of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.202A Unspecified open wound of left back wall of thorax without penetration into thoracic cavity, initial encounter

ICD-10-CM - Code and Description

S21.209A Unspecified open wound of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.211A Laceration without foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.212A Laceration without foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.219A Laceration without foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.221A Laceration with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.222A Laceration with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.229A Laceration with foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.231A Puncture wound without foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.232A Puncture wound without foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.239A Puncture wound without foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.241A Puncture wound with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.242A Puncture wound with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.249A Puncture wound with foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.251A Open bite of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.252A Open bite of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.259A Open bite of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.90XA Unspecified open wound of unspecified part of thorax, initial encounter

S21.91XA Laceration without foreign body of unspecified part of thorax, initial encounter

S21.92XA Laceration with foreign body of unspecified part of thorax, initial encounter

S21.93XA Puncture wound without foreign body of unspecified part of thorax, initial encounter

ICD-10-CM - Code and Description

S21.94XA Puncture wound with foreign body of unspecified part of thorax, initial encounter

S21.95XA Open bite of unspecified part of thorax, initial encounter

S28.1XXA Traumatic amputation (partial) of part of thorax, except breast, initial encounter

S28.211A Complete traumatic amputation of right breast, initial encounter

S28.212A Complete traumatic amputation of left breast, initial encounter

S28.219A Complete traumatic amputation of unspecified breast, initial encounter

S28.221A Partial traumatic amputation of right breast, initial encounter

S28.222A Partial traumatic amputation of left breast, initial encounter

S28.229A Partial traumatic amputation of unspecified breast, initial encounter

S29.021A Laceration of muscle and tendon of front wall of thorax, initial encounter

S29.022A Laceration of muscle and tendon of back wall of thorax, initial encounter

S29.029A Laceration of muscle and tendon of unspecified wall of thorax, initial encounter

S31.000A Unspecified open wound of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.010A Laceration without foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.020A Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.030A Puncture wound without foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.040A Puncture wound with foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.050A Open bite of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.100A Unspecified open wound of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.101A Unspecified open wound of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.102A Unspecified open wound of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter

S31.103A Unspecified open wound of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.104A Unspecified open wound of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter

ICD-10-CM - Code and Description

S31.105A Unspecified open wound of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.109A Unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.110A Laceration without foreign body of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.111A Laceration without foreign body of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.112A Laceration without foreign body of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter

S31.113A Laceration without foreign body of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.114A Laceration without foreign body of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.115A Laceration without foreign body of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.119A Laceration without foreign body of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.120A Laceration of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.121A Laceration of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.122A Laceration of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity, initial encounter

S31.123A Laceration of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.124A Laceration of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.125A Laceration of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.129A Laceration of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.130A Puncture wound of abdominal wall without foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.131A Puncture wound of abdominal wall without foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.132A Puncture wound of abdominal wall without foreign body, epigastric region without penetration into peritoneal cavity, initial encounter

ICD-10-CM - Code and Description

S31.133A Puncture wound of abdominal wall without foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.134A Puncture wound of abdominal wall without foreign body, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.135A Puncture wound of abdominal wall without foreign body, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.139A Puncture wound of abdominal wall without foreign body, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.140A Puncture wound of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.141A Puncture wound of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.142A Puncture wound of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity, initial encounter

S31.143A Puncture wound of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.144A Puncture wound of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.145A Puncture wound of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.149A Puncture wound of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.150A Open bite of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.151A Open bite of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.152A Open bite of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter

S31.153A Open bite of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.154A Open bite of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.155A Open bite of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.159A Open bite of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.20XA Unspecified open wound of penis, initial encounter

S31.21XA Laceration without foreign body of penis, initial encounter

S31.22XA Laceration with foreign body of penis, initial encounter

ICD-10-CM - Code and Description

S31.23XA Puncture wound without foreign body of penis, initial encounter

S31.24XA Puncture wound with foreign body of penis, initial encounter

S31.25XA Open bite of penis, initial encounter

S31.30XA Unspecified open wound of scrotum and testes, initial encounter

S31.31XA Laceration without foreign body of scrotum and testes, initial encounter

S31.32XA Laceration with foreign body of scrotum and testes, initial encounter

S31.33XA Puncture wound without foreign body of scrotum and testes, initial encounter

S31.34XA Puncture wound with foreign body of scrotum and testes, initial encounter

S31.35XA Open bite of scrotum and testes, initial encounter

S31.40XA Unspecified open wound of vagina and vulva, initial encounter

S31.41XA Laceration without foreign body of vagina and vulva, initial encounter

S31.42XA Laceration with foreign body of vagina and vulva, initial encounter

S31.43XA Puncture wound without foreign body of vagina and vulva, initial encounter

S31.44XA Puncture wound with foreign body of vagina and vulva, initial encounter

S31.45XA Open bite of vagina and vulva, initial encounter

S31.501A Unspecified open wound of unspecified external genital organs, male, initial encounter

S31.502A Unspecified open wound of unspecified external genital organs, female, initial encounter

S31.511A Laceration without foreign body of unspecified external genital organs, male, initial encounter

S31.512A Laceration without foreign body of unspecified external genital organs, female, initial encounter

S31.521A Laceration with foreign body of unspecified external genital organs, male, initial encounter

S31.522A Laceration with foreign body of unspecified external genital organs, female, initial encounter

S31.531A Puncture wound without foreign body of unspecified external genital organs, male, initial encounter

S31.532A Puncture wound without foreign body of unspecified external genital organs, female, initial encounter

S31.541A Puncture wound with foreign body of unspecified external genital organs, male, initial encounter

S31.542A Puncture wound with foreign body of unspecified external genital organs, female, initial encounter

S31.551A Open bite of unspecified external genital organs, male, initial encounter

S31.552A Open bite of unspecified external genital organs, female, initial encounter

ICD-10-CM - Code and Description

S31.801A Laceration without foreign body of unspecified buttock, initial encounter

S31.802A Laceration with foreign body of unspecified buttock, initial encounter

S31.803A Puncture wound without foreign body of unspecified buttock, initial encounter

S31.804A Puncture wound with foreign body of unspecified buttock, initial encounter

S31.805A Open bite of unspecified buttock, initial encounter

S31.809A Unspecified open wound of unspecified buttock, initial encounter

S31.811A Laceration without foreign body of right buttock, initial encounter

S31.812A Laceration with foreign body of right buttock, initial encounter

S31.813A Puncture wound without foreign body of right buttock, initial encounter

S31.814A Puncture wound with foreign body of right buttock, initial encounter

S31.815A Open bite of right buttock, initial encounter

S31.819A Unspecified open wound of right buttock, initial encounter

S31.821A Laceration without foreign body of left buttock, initial encounter

S31.822A Laceration with foreign body of left buttock, initial encounter

S31.823A Puncture wound without foreign body of left buttock, initial encounter

S31.824A Puncture wound with foreign body of left buttock, initial encounter

S31.825A Open bite of left buttock, initial encounter

S31.829A Unspecified open wound of left buttock, initial encounter

S31.831A Laceration without foreign body of anus, initial encounter

S31.832A Laceration with foreign body of anus, initial encounter

S31.833A Puncture wound without foreign body of anus, initial encounter

S31.834A Puncture wound with foreign body of anus, initial encounter

S31.835A Open bite of anus, initial encounter

S31.839A Unspecified open wound of anus, initial encounter

S38.211A Complete traumatic amputation of female external genital organs, initial encounter

S38.212A Partial traumatic amputation of female external genital organs, initial encounter

S38.221A Complete traumatic amputation of penis, initial encounter

S38.222A Partial traumatic amputation of penis, initial encounter

S38.231A Complete traumatic amputation of scrotum and testis, initial encounter

S38.232A Partial traumatic amputation of scrotum and testis, initial encounter

S38.3XXA Transection (partial) of abdomen, initial encounter

S39.021A Laceration of muscle, fascia and tendon of abdomen, initial encounter

ICD-10-CM - Code and Description

S39.022A Laceration of muscle, fascia and tendon of lower back, initial encounter
S39.023A Laceration of muscle, fascia and tendon of pelvis, initial encounter
S41.001A Unspecified open wound of right shoulder, initial encounter
S41.002A Unspecified open wound of left shoulder, initial encounter
S41.009A Unspecified open wound of unspecified shoulder, initial encounter
S41.011A Laceration without foreign body of right shoulder, initial encounter
S41.012A Laceration without foreign body of left shoulder, initial encounter
S41.019A Laceration without foreign body of unspecified shoulder, initial encounter
S41.021A Laceration with foreign body of right shoulder, initial encounter
S41.022A Laceration with foreign body of left shoulder, initial encounter
S41.029A Laceration with foreign body of unspecified shoulder, initial encounter
S41.031A Puncture wound without foreign body of right shoulder, initial encounter
S41.032A Puncture wound without foreign body of left shoulder, initial encounter
S41.039A Puncture wound without foreign body of unspecified shoulder, initial encounter

S41.041A Puncture wound with foreign body of right shoulder, initial encounter
S41.042A Puncture wound with foreign body of left shoulder, initial encounter
S41.049A Puncture wound with foreign body of unspecified shoulder, initial encounter
S41.051A Open bite of right shoulder, initial encounter
S41.052A Open bite of left shoulder, initial encounter
S41.059A Open bite of unspecified shoulder, initial encounter
S41.101A Unspecified open wound of right upper arm, initial encounter
S41.102A Unspecified open wound of left upper arm, initial encounter
S41.109A Unspecified open wound of unspecified upper arm, initial encounter
S41.111A Laceration without foreign body of right upper arm, initial encounter
S41.112A Laceration without foreign body of left upper arm, initial encounter
S41.119A Laceration without foreign body of unspecified upper arm, initial encounter
S41.121A Laceration with foreign body of right upper arm, initial encounter
S41.122A Laceration with foreign body of left upper arm, initial encounter
S41.129A Laceration with foreign body of unspecified upper arm, initial encounter
S41.131A Puncture wound without foreign body of right upper arm, initial encounter
S41.132A Puncture wound without foreign body of left upper arm, initial encounter
S41.139A Puncture wound without foreign body of unspecified upper arm, initial encounter

S41.141A Puncture wound with foreign body of right upper arm, initial encounter

ICD-10-CM - Code and Description

S41.142A Puncture wound with foreign body of left upper arm, initial encounter

S41.149A Puncture wound with foreign body of unspecified upper arm, initial encounter

S41.151A Open bite of right upper arm, initial encounter

S41.152A Open bite of left upper arm, initial encounter

S41.159A Open bite of unspecified upper arm, initial encounter

S46.021A Laceration of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter

S46.022A Laceration of muscle(s) and tendon(s) of the rotator cuff of left shoulder, initial encounter

S46.029A Laceration of muscle(s) and tendon(s) of the rotator cuff of unspecified shoulder, initial encounter

S46.121A Laceration of muscle, fascia and tendon of long head of biceps, right arm, initial encounter

S46.122A Laceration of muscle, fascia and tendon of long head of biceps, left arm, initial encounter

S46.129A Laceration of muscle, fascia and tendon of long head of biceps, unspecified arm, initial encounter

S46.221A Laceration of muscle, fascia and tendon of other parts of biceps, right arm, initial encounter

S46.222A Laceration of muscle, fascia and tendon of other parts of biceps, left arm, initial encounter

S46.229A Laceration of muscle, fascia and tendon of other parts of biceps, unspecified arm, initial encounter

S46.321A Laceration of muscle, fascia and tendon of triceps, right arm, initial encounter

S46.322A Laceration of muscle, fascia and tendon of triceps, left arm, initial encounter

S46.329A Laceration of muscle, fascia and tendon of triceps, unspecified arm, initial encounter

S46.821A Laceration of other muscles, fascia and tendons at shoulder and upper arm level, right arm, initial encounter

S46.822A Laceration of other muscles, fascia and tendons at shoulder and upper arm level, left arm, initial encounter

S46.829A Laceration of other muscles, fascia and tendons at shoulder and upper arm level, unspecified arm, initial encounter

S46.921A Laceration of unspecified muscle, fascia and tendon at shoulder and upper arm level, right arm, initial encounter

S46.922A Laceration of unspecified muscle, fascia and tendon at shoulder and upper arm level, left arm, initial encounter

ICD-10-CM - Code and Description

S46.929A Laceration of unspecified muscle, fascia and tendon at shoulder and upper arm level, unspecified arm, initial encounter

S48.011A Complete traumatic amputation at right shoulder joint, initial encounter

S48.012A Complete traumatic amputation at left shoulder joint, initial encounter

S48.019A Complete traumatic amputation at unspecified shoulder joint, initial encounter

S48.021A Partial traumatic amputation at right shoulder joint, initial encounter

S48.022A Partial traumatic amputation at left shoulder joint, initial encounter

S48.029A Partial traumatic amputation at unspecified shoulder joint, initial encounter

S48.111A Complete traumatic amputation at level between right shoulder and elbow, initial encounter

S48.112A Complete traumatic amputation at level between left shoulder and elbow, initial encounter

S48.119A Complete traumatic amputation at level between unspecified shoulder and elbow, initial encounter

S48.121A Partial traumatic amputation at level between right shoulder and elbow, initial encounter

S48.122A Partial traumatic amputation at level between left shoulder and elbow, initial encounter

S48.129A Partial traumatic amputation at level between unspecified shoulder and elbow, initial encounter

S48.911A Complete traumatic amputation of right shoulder and upper arm, level unspecified, initial encounter

S48.912A Complete traumatic amputation of left shoulder and upper arm, level unspecified, initial encounter

S48.919A Complete traumatic amputation of unspecified shoulder and upper arm, level unspecified, initial encounter

S48.921A Partial traumatic amputation of right shoulder and upper arm, level unspecified, initial encounter

S48.922A Partial traumatic amputation of left shoulder and upper arm, level unspecified, initial encounter

S48.929A Partial traumatic amputation of unspecified shoulder and upper arm, level unspecified, initial encounter

S51.001A Unspecified open wound of right elbow, initial encounter

S51.002A Unspecified open wound of left elbow, initial encounter

S51.009A Unspecified open wound of unspecified elbow, initial encounter

S51.011A Laceration without foreign body of right elbow, initial encounter

S51.012A Laceration without foreign body of left elbow, initial encounter

ICD-10-CM - Code and Description

S51.019A Laceration without foreign body of unspecified elbow, initial encounter
S51.021A Laceration with foreign body of right elbow, initial encounter
S51.022A Laceration with foreign body of left elbow, initial encounter
S51.029A Laceration with foreign body of unspecified elbow, initial encounter
S51.031A Puncture wound without foreign body of right elbow, initial encounter
S51.032A Puncture wound without foreign body of left elbow, initial encounter
S51.039A Puncture wound without foreign body of unspecified elbow, initial encounter
S51.041A Puncture wound with foreign body of right elbow, initial encounter
S51.042A Puncture wound with foreign body of left elbow, initial encounter
S51.049A Puncture wound with foreign body of unspecified elbow, initial encounter
S51.051A Open bite, right elbow, initial encounter
S51.052A Open bite, left elbow, initial encounter
S51.059A Open bite, unspecified elbow, initial encounter
S51.801A Unspecified open wound of right forearm, initial encounter
S51.802A Unspecified open wound of left forearm, initial encounter
S51.809A Unspecified open wound of unspecified forearm, initial encounter
S51.811A Laceration without foreign body of right forearm, initial encounter
S51.812A Laceration without foreign body of left forearm, initial encounter
S51.819A Laceration without foreign body of unspecified forearm, initial encounter
S51.821A Laceration with foreign body of right forearm, initial encounter
S51.822A Laceration with foreign body of left forearm, initial encounter
S51.829A Laceration with foreign body of unspecified forearm, initial encounter
S51.831A Puncture wound without foreign body of right forearm, initial encounter
S51.832A Puncture wound without foreign body of left forearm, initial encounter
S51.839A Puncture wound without foreign body of unspecified forearm, initial encounter

S51.841A Puncture wound with foreign body of right forearm, initial encounter
S51.842A Puncture wound with foreign body of left forearm, initial encounter
S51.849A Puncture wound with foreign body of unspecified forearm, initial encounter
S51.851A Open bite of right forearm, initial encounter
S51.852A Open bite of left forearm, initial encounter
S51.859A Open bite of unspecified forearm, initial encounter
S56.021A Laceration of flexor muscle, fascia and tendon of right thumb at forearm level, initial encounter

ICD-10-CM - Code and Description

S56.022A Laceration of flexor muscle, fascia and tendon of left thumb at forearm level, initial encounter

S56.029A Laceration of flexor muscle, fascia and tendon of unspecified thumb at forearm level, initial encounter

S56.121A Laceration of flexor muscle, fascia and tendon of right index finger at forearm level, initial encounter

S56.122A Laceration of flexor muscle, fascia and tendon of left index finger at forearm level, initial encounter

S56.123A Laceration of flexor muscle, fascia and tendon of right middle finger at forearm level, initial encounter

S56.124A Laceration of flexor muscle, fascia and tendon of left middle finger at forearm level, initial encounter

S56.125A Laceration of flexor muscle, fascia and tendon of right ring finger at forearm level, initial encounter

S56.126A Laceration of flexor muscle, fascia and tendon of left ring finger at forearm level, initial encounter

S56.127A Laceration of flexor muscle, fascia and tendon of right little finger at forearm level, initial encounter

S56.128A Laceration of flexor muscle, fascia and tendon of left little finger at forearm level, initial encounter

S56.129A Laceration of flexor muscle, fascia and tendon of unspecified finger at forearm level, initial encounter

S56.221A Laceration of other flexor muscle, fascia and tendon at forearm level, right arm, initial encounter

S56.222A Laceration of other flexor muscle, fascia and tendon at forearm level, left arm, initial encounter

S56.229A Laceration of other flexor muscle, fascia and tendon at forearm level, unspecified arm, initial encounter

S56.321A Laceration of extensor or abductor muscles, fascia and tendons of right thumb at forearm level, initial encounter

S56.322A Laceration of extensor or abductor muscles, fascia and tendons of left thumb at forearm level, initial encounter

S56.329A Laceration of extensor or abductor muscles, fascia and tendons of unspecified thumb at forearm level, initial encounter

S56.421A Laceration of extensor muscle, fascia and tendon of right index finger at forearm level, initial encounter

S56.422A Laceration of extensor muscle, fascia and tendon of left index finger at forearm level, initial encounter

ICD-10-CM - Code and Description

S56.423A Laceration of extensor muscle, fascia and tendon of right middle finger at forearm level, initial encounter

S56.424A Laceration of extensor muscle, fascia and tendon of left middle finger at forearm level, initial encounter

S56.425A Laceration of extensor muscle, fascia and tendon of right ring finger at forearm level, initial encounter

S56.426A Laceration of extensor muscle, fascia and tendon of left ring finger at forearm level, initial encounter

S56.427A Laceration of extensor muscle, fascia and tendon of right little finger at forearm level, initial encounter

S56.428A Laceration of extensor muscle, fascia and tendon of left little finger at forearm level, initial encounter

S56.429A Laceration of extensor muscle, fascia and tendon of unspecified finger at forearm level, initial encounter

S56.521A Laceration of other extensor muscle, fascia and tendon at forearm level, right arm, initial encounter

S56.522A Laceration of other extensor muscle, fascia and tendon at forearm level, left arm, initial encounter

S56.529A Laceration of other extensor muscle, fascia and tendon at forearm level, unspecified arm, initial encounter

S56.821A Laceration of other muscles, fascia and tendons at forearm level, right arm, initial encounter

S56.822A Laceration of other muscles, fascia and tendons at forearm level, left arm, initial encounter

S56.829A Laceration of other muscles, fascia and tendons at forearm level, unspecified arm, initial encounter

S56.921A Laceration of unspecified muscles, fascia and tendons at forearm level, right arm, initial encounter

S56.922A Laceration of unspecified muscles, fascia and tendons at forearm level, left arm, initial encounter

S56.929A Laceration of unspecified muscles, fascia and tendons at forearm level, unspecified arm, initial encounter

S58.011A Complete traumatic amputation at elbow level, right arm, initial encounter

S58.012A Complete traumatic amputation at elbow level, left arm, initial encounter

S58.019A Complete traumatic amputation at elbow level, unspecified arm, initial encounter

S58.021A Partial traumatic amputation at elbow level, right arm, initial encounter

S58.022A Partial traumatic amputation at elbow level, left arm, initial encounter

ICD-10-CM - Code and Description

S58.029A Partial traumatic amputation at elbow level, unspecified arm, initial encounter

S58.111A Complete traumatic amputation at level between elbow and wrist, right arm, initial encounter

S58.112A Complete traumatic amputation at level between elbow and wrist, left arm, initial encounter

S58.119A Complete traumatic amputation at level between elbow and wrist, unspecified arm, initial encounter

S58.121A Partial traumatic amputation at level between elbow and wrist, right arm, initial encounter

S58.122A Partial traumatic amputation at level between elbow and wrist, left arm, initial encounter

S58.129A Partial traumatic amputation at level between elbow and wrist, unspecified arm, initial encounter

S58.911A Complete traumatic amputation of right forearm, level unspecified, initial encounter

S58.912A Complete traumatic amputation of left forearm, level unspecified, initial encounter

S58.919A Complete traumatic amputation of unspecified forearm, level unspecified, initial encounter

S58.921A Partial traumatic amputation of right forearm, level unspecified, initial encounter

S58.922A Partial traumatic amputation of left forearm, level unspecified, initial encounter

S58.929A Partial traumatic amputation of unspecified forearm, level unspecified, initial encounter

S61.001A Unspecified open wound of right thumb without damage to nail, initial encounter

S61.002A Unspecified open wound of left thumb without damage to nail, initial encounter

S61.009A Unspecified open wound of unspecified thumb without damage to nail, initial encounter

S61.011A Laceration without foreign body of right thumb without damage to nail, initial encounter

S61.012A Laceration without foreign body of left thumb without damage to nail, initial encounter

S61.019A Laceration without foreign body of unspecified thumb without damage to nail, initial encounter

S61.021A Laceration with foreign body of right thumb without damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.022A Laceration with foreign body of left thumb without damage to nail, initial encounter

S61.029A Laceration with foreign body of unspecified thumb without damage to nail, initial encounter

S61.031A Puncture wound without foreign body of right thumb without damage to nail, initial encounter

S61.032A Puncture wound without foreign body of left thumb without damage to nail, initial encounter

S61.039A Puncture wound without foreign body of unspecified thumb without damage to nail, initial encounter

S61.041A Puncture wound with foreign body of right thumb without damage to nail, initial encounter

S61.042A Puncture wound with foreign body of left thumb without damage to nail, initial encounter

S61.049A Puncture wound with foreign body of unspecified thumb without damage to nail, initial encounter

S61.051A Open bite of right thumb without damage to nail, initial encounter

S61.052A Open bite of left thumb without damage to nail, initial encounter

S61.059A Open bite of unspecified thumb without damage to nail, initial encounter

S61.101A Unspecified open wound of right thumb with damage to nail, initial encounter

S61.102A Unspecified open wound of left thumb with damage to nail, initial encounter

S61.109A Unspecified open wound of unspecified thumb with damage to nail, initial encounter

S61.109A Unspecified open wound of unspecified thumb with damage to nail, initial encounter

S61.111A Laceration without foreign body of right thumb with damage to nail, initial encounter

S61.112A Laceration without foreign body of left thumb with damage to nail, initial encounter

S61.119A Laceration without foreign body of unspecified thumb with damage to nail, initial encounter

S61.121A Laceration with foreign body of right thumb with damage to nail, initial encounter

S61.122A Laceration with foreign body of left thumb with damage to nail, initial encounter

S61.129A Laceration with foreign body of unspecified thumb with damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.131A Puncture wound without foreign body of right thumb with damage to nail, initial encounter

S61.132A Puncture wound without foreign body of left thumb with damage to nail, initial encounter

S61.139A Puncture wound without foreign body of unspecified thumb with damage to nail, initial encounter

S61.141A Puncture wound with foreign body of right thumb with damage to nail, initial encounter

S61.142A Puncture wound with foreign body of left thumb with damage to nail, initial encounter

S61.149A Puncture wound with foreign body of unspecified thumb with damage to nail, initial encounter

S61.151A Open bite of right thumb with damage to nail, initial encounter

S61.152A Open bite of left thumb with damage to nail, initial encounter

S61.159A Open bite of unspecified thumb with damage to nail, initial encounter

S61.200A Unspecified open wound of right index finger without damage to nail, initial encounter

S61.201A Unspecified open wound of left index finger without damage to nail, initial encounter

S61.202A Unspecified open wound of right middle finger without damage to nail, initial encounter

S61.203A Unspecified open wound of left middle finger without damage to nail, initial encounter

S61.204A Unspecified open wound of right ring finger without damage to nail, initial encounter

S61.205A Unspecified open wound of left ring finger without damage to nail, initial encounter

S61.206A Unspecified open wound of right little finger without damage to nail, initial encounter

S61.207A Unspecified open wound of left little finger without damage to nail, initial encounter

S61.208A Unspecified open wound of other finger without damage to nail, initial encounter

S61.209A Unspecified open wound of unspecified finger without damage to nail, initial encounter

S61.209A Unspecified open wound of unspecified finger without damage to nail, initial encounter

S61.210A Laceration without foreign body of right index finger without damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.211A Laceration without foreign body of left index finger without damage to nail, initial encounter

S61.212A Laceration without foreign body of right middle finger without damage to nail, initial encounter

S61.213A Laceration without foreign body of left middle finger without damage to nail, initial encounter

S61.214A Laceration without foreign body of right ring finger without damage to nail, initial encounter

S61.215A Laceration without foreign body of left ring finger without damage to nail, initial encounter

S61.216A Laceration without foreign body of right little finger without damage to nail, initial encounter

S61.217A Laceration without foreign body of left little finger without damage to nail, initial encounter

S61.218A Laceration without foreign body of other finger without damage to nail, initial encounter

S61.219A Laceration without foreign body of unspecified finger without damage to nail, initial encounter

S61.220A Laceration with foreign body of right index finger without damage to nail, initial encounter

S61.221A Laceration with foreign body of left index finger without damage to nail, initial encounter

S61.222A Laceration with foreign body of right middle finger without damage to nail, initial encounter

S61.223A Laceration with foreign body of left middle finger without damage to nail, initial encounter

S61.224A Laceration with foreign body of right ring finger without damage to nail, initial encounter

S61.225A Laceration with foreign body of left ring finger without damage to nail, initial encounter

S61.226A Laceration with foreign body of right little finger without damage to nail, initial encounter

S61.227A Laceration with foreign body of left little finger without damage to nail, initial encounter

S61.228A Laceration with foreign body of other finger without damage to nail, initial encounter

S61.229A Laceration with foreign body of unspecified finger without damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.230A Puncture wound without foreign body of right index finger without damage to nail, initial encounter

S61.231A Puncture wound without foreign body of left index finger without damage to nail, initial encounter

S61.232A Puncture wound without foreign body of right middle finger without damage to nail, initial encounter

S61.233A Puncture wound without foreign body of left middle finger without damage to nail, initial encounter

S61.234A Puncture wound without foreign body of right ring finger without damage to nail, initial encounter

S61.235A Puncture wound without foreign body of left ring finger without damage to nail, initial encounter

S61.236A Puncture wound without foreign body of right little finger without damage to nail, initial encounter

S61.237A Puncture wound without foreign body of left little finger without damage to nail, initial encounter

S61.238A Puncture wound without foreign body of other finger without damage to nail, initial encounter

S61.239A Puncture wound without foreign body of unspecified finger without damage to nail, initial encounter

S61.240A Puncture wound with foreign body of right index finger without damage to nail, initial encounter

S61.241A Puncture wound with foreign body of left index finger without damage to nail, initial encounter

S61.242A Puncture wound with foreign body of right middle finger without damage to nail, initial encounter

S61.243A Puncture wound with foreign body of left middle finger without damage to nail, initial encounter

S61.244A Puncture wound with foreign body of right ring finger without damage to nail, initial encounter

S61.245A Puncture wound with foreign body of left ring finger without damage to nail, initial encounter

S61.246A Puncture wound with foreign body of right little finger without damage to nail, initial encounter

S61.247A Puncture wound with foreign body of left little finger without damage to nail, initial encounter

S61.248A Puncture wound with foreign body of other finger without damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.249A Puncture wound with foreign body of unspecified finger without damage to nail, initial encounter

S61.250A Open bite of right index finger without damage to nail, initial encounter

S61.251A Open bite of left index finger without damage to nail, initial encounter

S61.252A Open bite of right middle finger without damage to nail, initial encounter

S61.253A Open bite of left middle finger without damage to nail, initial encounter

S61.254A Open bite of right ring finger without damage to nail, initial encounter

S61.255A Open bite of left ring finger without damage to nail, initial encounter

S61.256A Open bite of right little finger without damage to nail, initial encounter

S61.257A Open bite of left little finger without damage to nail, initial encounter

S61.258A Open bite of other finger without damage to nail, initial encounter

S61.259A Open bite of unspecified finger without damage to nail, initial encounter

S61.300A Unspecified open wound of right index finger with damage to nail, initial encounter

S61.301A Unspecified open wound of left index finger with damage to nail, initial encounter

S61.302A Unspecified open wound of right middle finger with damage to nail, initial encounter

S61.303A Unspecified open wound of left middle finger with damage to nail, initial encounter

S61.304A Unspecified open wound of right ring finger with damage to nail, initial encounter

S61.305A Unspecified open wound of left ring finger with damage to nail, initial encounter

S61.306A Unspecified open wound of right little finger with damage to nail, initial encounter

S61.307A Unspecified open wound of left little finger with damage to nail, initial encounter

S61.308A Unspecified open wound of other finger with damage to nail, initial encounter

S61.309A Unspecified open wound of unspecified finger with damage to nail, initial encounter

S61.310A Laceration without foreign body of right index finger with damage to nail, initial encounter

S61.311A Laceration without foreign body of left index finger with damage to nail, initial encounter

S61.312A Laceration without foreign body of right middle finger with damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.313A Laceration without foreign body of left middle finger with damage to nail, initial encounter

S61.314A Laceration without foreign body of right ring finger with damage to nail, initial encounter

S61.315A Laceration without foreign body of left ring finger with damage to nail, initial encounter

S61.316A Laceration without foreign body of right little finger with damage to nail, initial encounter

S61.317A Laceration without foreign body of left little finger with damage to nail, initial encounter

S61.318A Laceration without foreign body of other finger with damage to nail, initial encounter

S61.319A Laceration without foreign body of unspecified finger with damage to nail, initial encounter

S61.320A Laceration with foreign body of right index finger with damage to nail, initial encounter

S61.321A Laceration with foreign body of left index finger with damage to nail, initial encounter

S61.322A Laceration with foreign body of right middle finger with damage to nail, initial encounter

S61.323A Laceration with foreign body of left middle finger with damage to nail, initial encounter

S61.324A Laceration with foreign body of right ring finger with damage to nail, initial encounter

S61.325A Laceration with foreign body of left ring finger with damage to nail, initial encounter

S61.326A Laceration with foreign body of right little finger with damage to nail, initial encounter

S61.327A Laceration with foreign body of left little finger with damage to nail, initial encounter

S61.328A Laceration with foreign body of other finger with damage to nail, initial encounter

S61.329A Laceration with foreign body of unspecified finger with damage to nail, initial encounter

S61.330A Puncture wound without foreign body of right index finger with damage to nail, initial encounter

S61.331A Puncture wound without foreign body of left index finger with damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.340A Puncture wound with foreign body of right index finger with damage to nail, initial encounter

S61.341A Puncture wound with foreign body of left index finger with damage to nail, initial encounter

S61.342A Puncture wound with foreign body of right middle finger with damage to nail, initial encounter

S61.343A Puncture wound with foreign body of left middle finger with damage to nail, initial encounter

S61.344A Puncture wound with foreign body of right ring finger with damage to nail, initial encounter

S61.345A Puncture wound with foreign body of left ring finger with damage to nail, initial encounter

S61.346A Puncture wound with foreign body of right little finger with damage to nail, initial encounter

S61.347A Puncture wound with foreign body of left little finger with damage to nail, initial encounter

S61.348A Puncture wound with foreign body of other finger with damage to nail, initial encounter

S61.349A Puncture wound with foreign body of unspecified finger with damage to nail, initial encounter

S61.401A Unspecified open wound of right hand, initial encounter

S61.402A Unspecified open wound of left hand, initial encounter

S61.409A Unspecified open wound of unspecified hand, initial encounter

S61.411A Laceration without foreign body of right hand, initial encounter

S61.412A Laceration without foreign body of left hand, initial encounter

S61.419A Laceration without foreign body of unspecified hand, initial encounter

S61.421A Laceration with foreign body of right hand, initial encounter

S61.422A Laceration with foreign body of left hand, initial encounter

S61.429A Laceration with foreign body of unspecified hand, initial encounter

S61.431A Puncture wound without foreign body of right hand, initial encounter

S61.432A Puncture wound without foreign body of left hand, initial encounter

S61.439A Puncture wound without foreign body of unspecified hand, initial encounter

S61.441A Puncture wound with foreign body of right hand, initial encounter

S61.442A Puncture wound with foreign body of left hand, initial encounter

S61.449A Puncture wound with foreign body of unspecified hand, initial encounter

S61.451A Open bite of right hand, initial encounter

S61.452A Open bite of left hand, initial encounter

ICD-10-CM - Code and Description

S61.459A Open bite of unspecified hand, initial encounter

S61.501A Unspecified open wound of right wrist, initial encounter

S61.502A Unspecified open wound of left wrist, initial encounter

S61.509A Unspecified open wound of unspecified wrist, initial encounter

S61.511A Laceration without foreign body of right wrist, initial encounter

S61.512A Laceration without foreign body of left wrist, initial encounter

S61.519A Laceration without foreign body of unspecified wrist, initial encounter

S61.521A Laceration with foreign body of right wrist, initial encounter

S61.522A Laceration with foreign body of left wrist, initial encounter

S61.529A Laceration with foreign body of unspecified wrist, initial encounter

S61.531A Puncture wound without foreign body of right wrist, initial encounter

S61.532A Puncture wound without foreign body of left wrist, initial encounter

S61.539A Puncture wound without foreign body of unspecified wrist, initial encounter

S61.541A Puncture wound with foreign body of right wrist, initial encounter

S61.542A Puncture wound with foreign body of left wrist, initial encounter

S61.549A Puncture wound with foreign body of unspecified wrist, initial encounter

S61.551A Open bite of right wrist, initial encounter

S61.552A Open bite of left wrist, initial encounter

S61.559A Open bite of unspecified wrist, initial encounter

S66.021A Laceration of long flexor muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter

S66.022A Laceration of long flexor muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter

S66.029A Laceration of long flexor muscle, fascia and tendon of unspecified thumb at wrist and hand level, initial encounter

S66.120A Laceration of flexor muscle, fascia and tendon of right index finger at wrist and hand level, initial encounter

S66.121A Laceration of flexor muscle, fascia and tendon of left index finger at wrist and hand level, initial encounter

S66.122A Laceration of flexor muscle, fascia and tendon of right middle finger at wrist and hand level, initial encounter

S66.123A Laceration of flexor muscle, fascia and tendon of left middle finger at wrist and hand level, initial encounter

S66.124A Laceration of flexor muscle, fascia and tendon of right ring finger at wrist and hand level, initial encounter

ICD-10-CM - Code and Description

S66.125A Laceration of flexor muscle, fascia and tendon of left ring finger at wrist and hand level, initial encounter

S66.126A Laceration of flexor muscle, fascia and tendon of right little finger at wrist and hand level, initial encounter

S66.127A Laceration of flexor muscle, fascia and tendon of left little finger at wrist and hand level, initial encounter

S66.128A Laceration of flexor muscle, fascia and tendon of other finger at wrist and hand level, initial encounter

S66.129A Laceration of flexor muscle, fascia and tendon of unspecified finger at wrist and hand level, initial encounter

S66.221A Laceration of extensor muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter

S66.222A Laceration of extensor muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter

S66.229A Laceration of extensor muscle, fascia and tendon of unspecified thumb at wrist and hand level, initial encounter

S66.320A Laceration of extensor muscle, fascia and tendon of right index finger at wrist and hand level, initial encounter

S66.321A Laceration of extensor muscle, fascia and tendon of left index finger at wrist and hand level, initial encounter

S66.322A Laceration of extensor muscle, fascia and tendon of right middle finger at wrist and hand level, initial encounter

S66.323A Laceration of extensor muscle, fascia and tendon of left middle finger at wrist and hand level, initial encounter

S66.324A Laceration of extensor muscle, fascia and tendon of right ring finger at wrist and hand level, initial encounter

S66.325A Laceration of extensor muscle, fascia and tendon of left ring finger at wrist and hand level, initial encounter

S66.326A Laceration of extensor muscle, fascia and tendon of right little finger at wrist and hand level, initial encounter

S66.327A Laceration of extensor muscle, fascia and tendon of left little finger at wrist and hand level, initial encounter

S66.328A Laceration of extensor muscle, fascia and tendon of other finger at wrist and hand level, initial encounter

S66.329A Laceration of extensor muscle, fascia and tendon of unspecified finger at wrist and hand level, initial encounter

S66.421A Laceration of intrinsic muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter

ICD-10-CM - Code and Description

S66.422A Laceration of intrinsic muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter

S66.429A Laceration of intrinsic muscle, fascia and tendon of unspecified thumb at wrist and hand level, initial encounter

S66.520A Laceration of intrinsic muscle, fascia and tendon of right index finger at wrist and hand level, initial encounter

S66.521A Laceration of intrinsic muscle, fascia and tendon of left index finger at wrist and hand level, initial encounter

S66.522A Laceration of intrinsic muscle, fascia and tendon of right middle finger at wrist and hand level, initial encounter

S66.523A Laceration of intrinsic muscle, fascia and tendon of left middle finger at wrist and hand level, initial encounter

S66.524A Laceration of intrinsic muscle, fascia and tendon of right ring finger at wrist and hand level, initial encounter

S66.525A Laceration of intrinsic muscle, fascia and tendon of left ring finger at wrist and hand level, initial encounter

S66.526A Laceration of intrinsic muscle, fascia and tendon of right little finger at wrist and hand level, initial encounter

S66.527A Laceration of intrinsic muscle, fascia and tendon of left little finger at wrist and hand level, initial encounter

S66.528A Laceration of intrinsic muscle, fascia and tendon of other finger at wrist and hand level, initial encounter

S66.529A Laceration of intrinsic muscle, fascia and tendon of unspecified finger at wrist and hand level, initial encounter

S66.821A Laceration of other specified muscles, fascia and tendons at wrist and hand level, right hand, initial encounter

S66.822A Laceration of other specified muscles, fascia and tendons at wrist and hand level, left hand, initial encounter

S66.829A Laceration of other specified muscles, fascia and tendons at wrist and hand level, unspecified hand, initial encounter

S66.921A Laceration of unspecified muscle, fascia and tendon at wrist and hand level, right hand, initial encounter

S66.922A Laceration of unspecified muscle, fascia and tendon at wrist and hand level, left hand, initial encounter

S66.929A Laceration of unspecified muscle, fascia and tendon at wrist and hand level, unspecified hand, initial encounter

S68.011A Complete traumatic metacarpophalangeal amputation of right thumb, initial encounter

ICD-10-CM - Code and Description

S68.012A Complete traumatic metacarpophalangeal amputation of left thumb, initial encounter

S68.019A Complete traumatic metacarpophalangeal amputation of unspecified thumb, initial encounter

S68.021A Partial traumatic metacarpophalangeal amputation of right thumb, initial encounter

S68.022A Partial traumatic metacarpophalangeal amputation of left thumb, initial encounter

S68.029A Partial traumatic metacarpophalangeal amputation of unspecified thumb, initial encounter

S68.110A Complete traumatic metacarpophalangeal amputation of right index finger, initial encounter

S68.111A Complete traumatic metacarpophalangeal amputation of left index finger, initial encounter

S68.112A Complete traumatic metacarpophalangeal amputation of right middle finger, initial encounter

S68.113A Complete traumatic metacarpophalangeal amputation of left middle finger, initial encounter

S68.114A Complete traumatic metacarpophalangeal amputation of right ring finger, initial encounter

S68.115A Complete traumatic metacarpophalangeal amputation of left ring finger, initial encounter

S68.116A Complete traumatic metacarpophalangeal amputation of right little finger, initial encounter

S68.117A Complete traumatic metacarpophalangeal amputation of left little finger, initial encounter

S68.118A Complete traumatic metacarpophalangeal amputation of other finger, initial encounter

S68.119A Complete traumatic metacarpophalangeal amputation of unspecified finger, initial encounter

S68.120A Partial traumatic metacarpophalangeal amputation of right index finger, initial encounter

S68.121A Partial traumatic metacarpophalangeal amputation of left index finger, initial encounter

S68.122A Partial traumatic metacarpophalangeal amputation of right middle finger, initial encounter

S68.123A Partial traumatic metacarpophalangeal amputation of left middle finger, initial encounter

ICD-10-CM - Code and Description

S68.124A Partial traumatic metacarpophalangeal amputation of right ring finger, initial encounter

S68.125A Partial traumatic metacarpophalangeal amputation of left ring finger, initial encounter

S68.126A Partial traumatic metacarpophalangeal amputation of right little finger, initial encounter

S68.127A Partial traumatic metacarpophalangeal amputation of left little finger, initial encounter

S68.128A Partial traumatic metacarpophalangeal amputation of other finger, initial encounter

S68.129A Partial traumatic metacarpophalangeal amputation of unspecified finger, initial encounter

S68.411A Complete traumatic amputation of right hand at wrist level, initial encounter

S68.412A Complete traumatic amputation of left hand at wrist level, initial encounter

S68.419A Complete traumatic amputation of unspecified hand at wrist level, initial encounter

S68.421A Partial traumatic amputation of right hand at wrist level, initial encounter

S68.422A Partial traumatic amputation of left hand at wrist level, initial encounter

S68.429A Partial traumatic amputation of unspecified hand at wrist level, initial encounter

S68.511A Complete traumatic transphalangeal amputation of right thumb, initial encounter

S68.512A Complete traumatic transphalangeal amputation of left thumb, initial encounter

S68.519A Complete traumatic transphalangeal amputation of unspecified thumb, initial encounter

S68.521A Partial traumatic transphalangeal amputation of right thumb, initial encounter

S68.522A Partial traumatic transphalangeal amputation of left thumb, initial encounter

S68.529A Partial traumatic transphalangeal amputation of unspecified thumb, initial encounter

S68.610A Complete traumatic transphalangeal amputation of right index finger, initial encounter

S68.611A Complete traumatic transphalangeal amputation of left index finger, initial encounter

S68.612A Complete traumatic transphalangeal amputation of right middle finger, initial encounter

S68.613A Complete traumatic transphalangeal amputation of left middle finger, initial encounter

ICD-10-CM - Code and Description

S68.614A Complete traumatic transphalangeal amputation of right ring finger, initial encounter

S68.615A Complete traumatic transphalangeal amputation of left ring finger, initial encounter

S68.616A Complete traumatic transphalangeal amputation of right little finger, initial encounter

S68.617A Complete traumatic transphalangeal amputation of left little finger, initial encounter

S68.618A Complete traumatic transphalangeal amputation of other finger, initial encounter

S68.619A Complete traumatic transphalangeal amputation of unspecified finger, initial encounter

S68.620A Partial traumatic transphalangeal amputation of right index finger, initial encounter

S68.621A Partial traumatic transphalangeal amputation of left index finger, initial encounter

S68.622A Partial traumatic transphalangeal amputation of right middle finger, initial encounter

S68.623A Partial traumatic transphalangeal amputation of left middle finger, initial encounter

S68.624A Partial traumatic transphalangeal amputation of right ring finger, initial encounter

S68.625A Partial traumatic transphalangeal amputation of left ring finger, initial encounter

S68.626A Partial traumatic transphalangeal amputation of right little finger, initial encounter

S68.627A Partial traumatic transphalangeal amputation of left little finger, initial encounter

S68.628A Partial traumatic transphalangeal amputation of other finger, initial encounter

S68.629A Partial traumatic transphalangeal amputation of unspecified finger, initial encounter

S68.711A Complete traumatic transmetacarpal amputation of right hand, initial encounter

S68.712A Complete traumatic transmetacarpal amputation of left hand, initial encounter

S68.719A Complete traumatic transmetacarpal amputation of unspecified hand, initial encounter

S68.721A Partial traumatic transmetacarpal amputation of right hand, initial encounter

S68.722A Partial traumatic transmetacarpal amputation of left hand, initial encounter

ICD-10-CM - Code and Description

S68.729A Partial traumatic transmetacarpal amputation of unspecified hand, initial encounter

S71.001A Unspecified open wound, right hip, initial encounter

S71.002A Unspecified open wound, left hip, initial encounter

S71.009A Unspecified open wound, unspecified hip, initial encounter

S71.011A Laceration without foreign body, right hip, initial encounter

S71.012A Laceration without foreign body, left hip, initial encounter

S71.019A Laceration without foreign body, unspecified hip, initial encounter

S71.021A Laceration with foreign body, right hip, initial encounter

S71.022A Laceration with foreign body, left hip, initial encounter

S71.029A Laceration with foreign body, unspecified hip, initial encounter

S71.031A Puncture wound without foreign body, right hip, initial encounter

S71.032A Puncture wound without foreign body, left hip, initial encounter

S71.039A Puncture wound without foreign body, unspecified hip, initial encounter

S71.041A Puncture wound with foreign body, right hip, initial encounter

S71.042A Puncture wound with foreign body, left hip, initial encounter

S71.049A Puncture wound with foreign body, unspecified hip, initial encounter

S71.051A Open bite, right hip, initial encounter

S71.052A Open bite, left hip, initial encounter

S71.059A Open bite, unspecified hip, initial encounter

S71.101A Unspecified open wound, right thigh, initial encounter

S71.102A Unspecified open wound, left thigh, initial encounter

S71.109A Unspecified open wound, unspecified thigh, initial encounter

S71.111A Laceration without foreign body, right thigh, initial encounter

S71.112A Laceration without foreign body, left thigh, initial encounter

S71.119A Laceration without foreign body, unspecified thigh, initial encounter

S71.121A Laceration with foreign body, right thigh, initial encounter

S71.122A Laceration with foreign body, left thigh, initial encounter

S71.129A Laceration with foreign body, unspecified thigh, initial encounter

S71.131A Puncture wound without foreign body, right thigh, initial encounter

S71.132A Puncture wound without foreign body, left thigh, initial encounter

S71.139A Puncture wound without foreign body, unspecified thigh, initial encounter

S71.141A Puncture wound with foreign body, right thigh, initial encounter

S71.142A Puncture wound with foreign body, left thigh, initial encounter

S71.149A Puncture wound with foreign body, unspecified thigh, initial encounter

ICD-10-CM - Code and Description

S71.151A Open bite, right thigh, initial encounter

S71.152A Open bite, left thigh, initial encounter

S71.159A Open bite, unspecified thigh, initial encounter

S76.021A Laceration of muscle, fascia and tendon of right hip, initial encounter

S76.022A Laceration of muscle, fascia and tendon of left hip, initial encounter

S76.029A Laceration of muscle, fascia and tendon of unspecified hip, initial encounter

S76.121A Laceration of right quadriceps muscle, fascia and tendon, initial encounter

S76.122A Laceration of left quadriceps muscle, fascia and tendon, initial encounter

S76.129A Laceration of unspecified quadriceps muscle, fascia and tendon, initial encounter

S76.221A Laceration of adductor muscle, fascia and tendon of right thigh, initial encounter

S76.222A Laceration of adductor muscle, fascia and tendon of left thigh, initial encounter

S76.229A Laceration of adductor muscle, fascia and tendon of unspecified thigh, initial encounter

S76.321A Laceration of muscle, fascia and tendon of the posterior muscle group at thigh level, right thigh, initial encounter

S76.322A Laceration of muscle, fascia and tendon of the posterior muscle group at thigh level, left thigh, initial encounter

S76.329A Laceration of muscle, fascia and tendon of the posterior muscle group at thigh level, unspecified thigh, initial encounter

S76.821A Laceration of other specified muscles, fascia and tendons at thigh level, right thigh, initial encounter

S76.822A Laceration of other specified muscles, fascia and tendons at thigh level, left thigh, initial encounter

S76.829A Laceration of other specified muscles, fascia and tendons at thigh level, unspecified thigh, initial encounter

S76.921A Laceration of unspecified muscles, fascia and tendons at thigh level, right thigh, initial encounter

S76.922A Laceration of unspecified muscles, fascia and tendons at thigh level, left thigh, initial encounter

S76.929A Laceration of unspecified muscles, fascia and tendons at thigh level, unspecified thigh, initial encounter

S78.011A Complete traumatic amputation at right hip joint, initial encounter

S78.012A Complete traumatic amputation at left hip joint, initial encounter

S78.019A Complete traumatic amputation at unspecified hip joint, initial encounter

ICD-10-CM - Code and Description

S78.021A Partial traumatic amputation at right hip joint, initial encounter

S78.022A Partial traumatic amputation at left hip joint, initial encounter

S78.029A Partial traumatic amputation at unspecified hip joint, initial encounter

S78.111A Complete traumatic amputation at level between right hip and knee, initial encounter

S78.112A Complete traumatic amputation at level between left hip and knee, initial encounter

S78.119A Complete traumatic amputation at level between unspecified hip and knee, initial encounter

S78.121A Partial traumatic amputation at level between right hip and knee, initial encounter

S78.122A Partial traumatic amputation at level between left hip and knee, initial encounter

S78.129A Partial traumatic amputation at level between unspecified hip and knee, initial encounter

S78.911A Complete traumatic amputation of right hip and thigh, level unspecified, initial encounter

S78.912A Complete traumatic amputation of left hip and thigh, level unspecified, initial encounter

S78.919A Complete traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter

S78.921A Partial traumatic amputation of right hip and thigh, level unspecified, initial encounter

S78.922A Partial traumatic amputation of left hip and thigh, level unspecified, initial encounter

S78.929A Partial traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter

S81.001A Unspecified open wound, right knee, initial encounter

S81.002A Unspecified open wound, left knee, initial encounter

S81.009A Unspecified open wound, unspecified knee, initial encounter

S81.011A Laceration without foreign body, right knee, initial encounter

S81.012A Laceration without foreign body, left knee, initial encounter

S81.019A Laceration without foreign body, unspecified knee, initial encounter

S81.021A Laceration with foreign body, right knee, initial encounter

S81.022A Laceration with foreign body, left knee, initial encounter

S81.029A Laceration with foreign body, unspecified knee, initial encounter

S81.031A Puncture wound without foreign body, right knee, initial encounter

ICD-10-CM - Code and Description

S81.032A Puncture wound without foreign body, left knee, initial encounter

S81.039A Puncture wound without foreign body, unspecified knee, initial encounter

S81.041A Puncture wound with foreign body, right knee, initial encounter

S81.042A Puncture wound with foreign body, left knee, initial encounter

S81.049A Puncture wound with foreign body, unspecified knee, initial encounter

S81.051A Open bite, right knee, initial encounter

S81.052A Open bite, left knee, initial encounter

S81.059A Open bite, unspecified knee, initial encounter

S81.801A Unspecified open wound, right lower leg, initial encounter

S81.802A Unspecified open wound, left lower leg, initial encounter

S81.809A Unspecified open wound, unspecified lower leg, initial encounter

S81.811A Laceration without foreign body, right lower leg, initial encounter

S81.812A Laceration without foreign body, left lower leg, initial encounter

S81.819A Laceration without foreign body, unspecified lower leg, initial encounter

S81.821A Laceration with foreign body, right lower leg, initial encounter

S81.822A Laceration with foreign body, left lower leg, initial encounter

S81.829A Laceration with foreign body, unspecified lower leg, initial encounter

S81.831A Puncture wound without foreign body, right lower leg, initial encounter

S81.832A Puncture wound without foreign body, left lower leg, initial encounter

S81.839A Puncture wound without foreign body, unspecified lower leg, initial encounter

S81.841A Puncture wound with foreign body, right lower leg, initial encounter

S81.842A Puncture wound with foreign body, left lower leg, initial encounter

S81.849A Puncture wound with foreign body, unspecified lower leg, initial encounter

S81.851A Open bite, right lower leg, initial encounter

S81.852A Open bite, left lower leg, initial encounter

S81.859A Open bite, unspecified lower leg, initial encounter

S86.021A Laceration of right Achilles tendon, initial encounter

S86.022A Laceration of left Achilles tendon, initial encounter

S86.029A Laceration of unspecified Achilles tendon, initial encounter

S86.121A Laceration of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, right leg, initial encounter

S86.122A Laceration of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, left leg, initial encounter

S86.129A Laceration of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, unspecified leg, initial encounter

ICD-10-CM - Code and Description

S86.221A Laceration of muscle(s) and tendon(s) of anterior muscle group at lower leg level, right leg, initial encounter

S86.222A Laceration of muscle(s) and tendon(s) of anterior muscle group at lower leg level, left leg, initial encounter

S86.229A Laceration of muscle(s) and tendon(s) of anterior muscle group at lower leg level, unspecified leg, initial encounter

S86.321A Laceration of muscle(s) and tendon(s) of peroneal muscle group at lower leg level, right leg, initial encounter

S86.322A Laceration of muscle(s) and tendon(s) of peroneal muscle group at lower leg level, left leg, initial encounter

S86.329A Laceration of muscle(s) and tendon(s) of peroneal muscle group at lower leg level, unspecified leg, initial encounter

S86.821A Laceration of other muscle(s) and tendon(s) at lower leg level, right leg, initial encounter

S86.822A Laceration of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter

S86.829A Laceration of other muscle(s) and tendon(s) at lower leg level, unspecified leg, initial encounter

S86.921A Laceration of unspecified muscle(s) and tendon(s) at lower leg level, right leg, initial encounter

S86.922A Laceration of unspecified muscle(s) and tendon(s) at lower leg level, left leg, initial encounter

S86.929A Laceration of unspecified muscle(s) and tendon(s) at lower leg level, unspecified leg, initial encounter

S88.011A Complete traumatic amputation at knee level, right lower leg, initial encounter

S88.012A Complete traumatic amputation at knee level, left lower leg, initial encounter

S88.019A Complete traumatic amputation at knee level, unspecified lower leg, initial encounter

S88.021A Partial traumatic amputation at knee level, right lower leg, initial encounter

S88.022A Partial traumatic amputation at knee level, left lower leg, initial encounter

S88.029A Partial traumatic amputation at knee level, unspecified lower leg, initial encounter

S88.111A Complete traumatic amputation at level between knee and ankle, right lower leg, initial encounter

S88.112A Complete traumatic amputation at level between knee and ankle, left lower leg, initial encounter

S88.119A Complete traumatic amputation at level between knee and ankle, unspecified lower leg, initial encounter

ICD-10-CM - Code and Description

S88.121A Partial traumatic amputation at level between knee and ankle, right lower leg, initial encounter

S88.122A Partial traumatic amputation at level between knee and ankle, left lower leg, initial encounter

S88.129A Partial traumatic amputation at level between knee and ankle, unspecified lower leg, initial encounter

S88.911A Complete traumatic amputation of right lower leg, level unspecified, initial encounter

S88.912A Complete traumatic amputation of left lower leg, level unspecified, initial encounter

S88.919A Complete traumatic amputation of unspecified lower leg, level unspecified, initial encounter

S88.921A Partial traumatic amputation of right lower leg, level unspecified, initial encounter

S88.922A Partial traumatic amputation of left lower leg, level unspecified, initial encounter

S88.929A Partial traumatic amputation of unspecified lower leg, level unspecified, initial encounter

S91.001A Unspecified open wound, right ankle, initial encounter

S91.002A Unspecified open wound, left ankle, initial encounter

S91.009A Unspecified open wound, unspecified ankle, initial encounter

S91.011A Laceration without foreign body, right ankle, initial encounter

S91.012A Laceration without foreign body, left ankle, initial encounter

S91.019A Laceration without foreign body, unspecified ankle, initial encounter

S91.021A Laceration with foreign body, right ankle, initial encounter

S91.022A Laceration with foreign body, left ankle, initial encounter

S91.029A Laceration with foreign body, unspecified ankle, initial encounter

S91.031A Puncture wound without foreign body, right ankle, initial encounter

S91.032A Puncture wound without foreign body, left ankle, initial encounter

S91.039A Puncture wound without foreign body, unspecified ankle, initial encounter

S91.041A Puncture wound with foreign body, right ankle, initial encounter

S91.042A Puncture wound with foreign body, left ankle, initial encounter

S91.049A Puncture wound with foreign body, unspecified ankle, initial encounter

S91.051A Open bite, right ankle, initial encounter

S91.052A Open bite, left ankle, initial encounter

S91.059A Open bite, unspecified ankle, initial encounter

ICD-10-CM - Code and Description

S91.101A Unspecified open wound of right great toe without damage to nail, initial encounter

S91.102A Unspecified open wound of left great toe without damage to nail, initial encounter

S91.103A Unspecified open wound of unspecified great toe without damage to nail, initial encounter

S91.104A Unspecified open wound of right lesser toe(s) without damage to nail, initial encounter

S91.105A Unspecified open wound of left lesser toe(s) without damage to nail, initial encounter

S91.106A Unspecified open wound of unspecified lesser toe(s) without damage to nail, initial encounter

S91.109A Unspecified open wound of unspecified toe(s) without damage to nail, initial encounter

S91.111A Laceration without foreign body of right great toe without damage to nail, initial encounter

S91.112A Laceration without foreign body of left great toe without damage to nail, initial encounter

S91.113A Laceration without foreign body of unspecified great toe without damage to nail, initial encounter

S91.114A Laceration without foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.115A Laceration without foreign body of left lesser toe(s) without damage to nail, initial encounter

S91.116A Laceration without foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.119A Laceration without foreign body of unspecified toe without damage to nail, initial encounter

S91.121A Laceration with foreign body of right great toe without damage to nail, initial encounter

S91.122A Laceration with foreign body of left great toe without damage to nail, initial encounter

S91.123A Laceration with foreign body of unspecified great toe without damage to nail, initial encounter

S91.124A Laceration with foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.125A Laceration with foreign body of left lesser toe(s) without damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.126A Laceration with foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.129A Laceration with foreign body of unspecified toe(s) without damage to nail, initial encounter

S91.131A Puncture wound without foreign body of right great toe without damage to nail, initial encounter

S91.132A Puncture wound without foreign body of left great toe without damage to nail, initial encounter

S91.133A Puncture wound without foreign body of unspecified great toe without damage to nail, initial encounter

S91.134A Puncture wound without foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.135A Puncture wound without foreign body of left lesser toe(s) without damage to nail, initial encounter

S91.136A Puncture wound without foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.139A Puncture wound without foreign body of unspecified toe(s) without damage to nail, initial encounter

S91.141A Puncture wound with foreign body of right great toe without damage to nail, initial encounter

S91.142A Puncture wound with foreign body of left great toe without damage to nail, initial encounter

S91.143A Puncture wound with foreign body of unspecified great toe without damage to nail, initial encounter

S91.144A Puncture wound with foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.145A Puncture wound with foreign body of left lesser toe(s) without damage to nail, initial encounter

S91.146A Puncture wound with foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.149A Puncture wound with foreign body of unspecified toe(s) without damage to nail, initial encounter

S91.151A Open bite of right great toe without damage to nail, initial encounter

S91.152A Open bite of left great toe without damage to nail, initial encounter

S91.153A Open bite of unspecified great toe without damage to nail, initial encounter

S91.154A Open bite of right lesser toe(s) without damage to nail, initial encounter

S91.155A Open bite of left lesser toe(s) without damage to nail, initial encounter

S91.156A Open bite of unspecified lesser toe(s) without damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.159A Open bite of unspecified toe(s) without damage to nail, initial encounter

S91.201A Unspecified open wound of right great toe with damage to nail, initial encounter

S91.202A Unspecified open wound of left great toe with damage to nail, initial encounter

S91.203A Unspecified open wound of unspecified great toe with damage to nail, initial encounter

S91.204A Unspecified open wound of right lesser toe(s) with damage to nail, initial encounter

S91.205A Unspecified open wound of left lesser toe(s) with damage to nail, initial encounter

S91.206A Unspecified open wound of unspecified lesser toe(s) with damage to nail, initial encounter

S91.209A Unspecified open wound of unspecified toe(s) with damage to nail, initial encounter

S91.211A Laceration without foreign body of right great toe with damage to nail, initial encounter

S91.212A Laceration without foreign body of left great toe with damage to nail, initial encounter

S91.213A Laceration without foreign body of unspecified great toe with damage to nail, initial encounter

S91.214A Laceration without foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.215A Laceration without foreign body of left lesser toe(s) with damage to nail, initial encounter

S91.216A Laceration without foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.219A Laceration without foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.221A Laceration with foreign body of right great toe with damage to nail, initial encounter

S91.222A Laceration with foreign body of left great toe with damage to nail, initial encounter

S91.223A Laceration with foreign body of unspecified great toe with damage to nail, initial encounter

S91.224A Laceration with foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.225A Laceration with foreign body of left lesser toe(s) with damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.226A Laceration with foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.229A Laceration with foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.231A Puncture wound without foreign body of right great toe with damage to nail, initial encounter

S91.232A Puncture wound without foreign body of left great toe with damage to nail, initial encounter

S91.233A Puncture wound without foreign body of unspecified great toe with damage to nail, initial encounter

S91.234A Puncture wound without foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.235A Puncture wound without foreign body of left lesser toe(s) with damage to nail, initial encounter

S91.236A Puncture wound without foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.239A Puncture wound without foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.241A Puncture wound with foreign body of right great toe with damage to nail, initial encounter

S91.242A Puncture wound with foreign body of left great toe with damage to nail, initial encounter

S91.243A Puncture wound with foreign body of unspecified great toe with damage to nail, initial encounter

S91.244A Puncture wound with foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.245A Puncture wound with foreign body of left lesser toe(s) with damage to nail, initial encounter

S91.246A Puncture wound with foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.249A Puncture wound with foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.251A Open bite of right great toe with damage to nail, initial encounter

S91.252A Open bite of left great toe with damage to nail, initial encounter

S91.253A Open bite of unspecified great toe with damage to nail, initial encounter

S91.254A Open bite of right lesser toe(s) with damage to nail, initial encounter

S91.255A Open bite of left lesser toe(s) with damage to nail, initial encounter

S91.256A Open bite of unspecified lesser toe(s) with damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.259A Open bite of unspecified toe(s) with damage to nail, initial encounter

S91.301A Unspecified open wound, right foot, initial encounter

S91.302A Unspecified open wound, left foot, initial encounter

S91.309A Unspecified open wound, unspecified foot, initial encounter

S91.311A Laceration without foreign body, right foot, initial encounter

S91.312A Laceration without foreign body, left foot, initial encounter

S91.319A Laceration without foreign body, unspecified foot, initial encounter

S91.321A Laceration with foreign body, right foot, initial encounter

S91.322A Laceration with foreign body, left foot, initial encounter

S91.329A Laceration with foreign body, unspecified foot, initial encounter

S91.331A Puncture wound without foreign body, right foot, initial encounter

S91.332A Puncture wound without foreign body, left foot, initial encounter

S91.339A Puncture wound without foreign body, unspecified foot, initial encounter

S91.341A Puncture wound with foreign body, right foot, initial encounter

S91.342A Puncture wound with foreign body, left foot, initial encounter

S91.349A Puncture wound with foreign body, unspecified foot, initial encounter

S91.351A Open bite, right foot, initial encounter

S91.352A Open bite, left foot, initial encounter

S91.359A Open bite, unspecified foot, initial encounter

S96.021A Laceration of muscle and tendon of long flexor muscle of toe at ankle and foot level, right foot, initial encounter

S96.022A Laceration of muscle and tendon of long flexor muscle of toe at ankle and foot level, left foot, initial encounter

S96.029A Laceration of muscle and tendon of long flexor muscle of toe at ankle and foot level, unspecified foot, initial encounter

S96.121A Laceration of muscle and tendon of long extensor muscle of toe at ankle and foot level, right foot, initial encounter

S96.122A Laceration of muscle and tendon of long extensor muscle of toe at ankle and foot level, left foot, initial encounter

S96.129A Laceration of muscle and tendon of long extensor muscle of toe at ankle and foot level, unspecified foot, initial encounter

S96.221A Laceration of intrinsic muscle and tendon at ankle and foot level, right foot, initial encounter

S96.222A Laceration of intrinsic muscle and tendon at ankle and foot level, left foot, initial encounter

ICD-10-CM - Code and Description

S96.229A Laceration of intrinsic muscle and tendon at ankle and foot level, unspecified foot, initial encounter

S96.821A Laceration of other specified muscles and tendons at ankle and foot level, right foot, initial encounter

S96.822A Laceration of other specified muscles and tendons at ankle and foot level, left foot, initial encounter

S96.829A Laceration of other specified muscles and tendons at ankle and foot level, unspecified foot, initial encounter

S96.921A Laceration of unspecified muscle and tendon at ankle and foot level, right foot, initial encounter

S96.922A Laceration of unspecified muscle and tendon at ankle and foot level, left foot, initial encounter

S96.929A Laceration of unspecified muscle and tendon at ankle and foot level, unspecified foot, initial encounter

S98.011A Complete traumatic amputation of right foot at ankle level, initial encounter

S98.012A Complete traumatic amputation of left foot at ankle level, initial encounter

S98.019A Complete traumatic amputation of unspecified foot at ankle level, initial encounter

S98.021A Partial traumatic amputation of right foot at ankle level, initial encounter

S98.022A Partial traumatic amputation of left foot at ankle level, initial encounter

S98.029A Partial traumatic amputation of unspecified foot at ankle level, initial encounter

S98.111A Complete traumatic amputation of right great toe, initial encounter

S98.112A Complete traumatic amputation of left great toe, initial encounter

S98.119A Complete traumatic amputation of unspecified great toe, initial encounter

S98.121A Partial traumatic amputation of right great toe, initial encounter

S98.122A Partial traumatic amputation of left great toe, initial encounter

S98.129A Partial traumatic amputation of unspecified great toe, initial encounter

S98.131A Complete traumatic amputation of one right lesser toe, initial encounter

S98.132A Complete traumatic amputation of one left lesser toe, initial encounter

S98.139A Complete traumatic amputation of one unspecified lesser toe, initial encounter

S98.141A Partial traumatic amputation of one right lesser toe, initial encounter

S98.142A Partial traumatic amputation of one left lesser toe, initial encounter

S98.149A Partial traumatic amputation of one unspecified lesser toe, initial encounter

S98.211A Complete traumatic amputation of two or more right lesser toes, initial encounter

ICD-10-CM - Code and Description

S98.212A Complete traumatic amputation of two or more left lesser toes, initial encounter

S98.219A Complete traumatic amputation of two or more unspecified lesser toes, initial encounter

S98.221A Partial traumatic amputation of two or more right lesser toes, initial encounter

S98.222A Partial traumatic amputation of two or more left lesser toes, initial encounter

S98.229A Partial traumatic amputation of two or more unspecified lesser toes, initial encounter

S98.311A Complete traumatic amputation of right midfoot, initial encounter

S98.312A Complete traumatic amputation of left midfoot, initial encounter

S98.319A Complete traumatic amputation of unspecified midfoot, initial encounter

S98.321A Partial traumatic amputation of right midfoot, initial encounter

S98.322A Partial traumatic amputation of left midfoot, initial encounter

S98.329A Partial traumatic amputation of unspecified midfoot, initial encounter

S98.911A Complete traumatic amputation of right foot, level unspecified, initial encounter

S98.912A Complete traumatic amputation of left foot, level unspecified, initial encounter

S98.919A Complete traumatic amputation of unspecified foot, level unspecified, initial encounter

S98.921A Partial traumatic amputation of right foot, level unspecified, initial encounter

S98.922A Partial traumatic amputation of left foot, level unspecified, initial encounter

S98.929A Partial traumatic amputation of unspecified foot, level unspecified, initial encounter

T81.31XA Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter

T81.32XA Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter

Transmittals Issued for this Chapter

Rev #	Issue Date	Subje ct	Impl Date	CR#
R3367CP	10/07/2015	Applying Therapy Caps to Maryland Hospitals	01/04/2016	9223
R3309CP	08/06/2015	Applying Therapy Caps to Maryland Hospitals – Rescinded and replaced by Transmittal 3367	01/04/2016	9223
R3220CP	03/16/2015	Update to Pub. 100-04, Chapters 5 and 6 to Provide Language-Only Changes for Updating ICD-10, ASC X12, and Medicare Administrative Contractor (MAC) Implementation	09/16/2014	8524
R3028CP	08/15/2014	Update to Pub. 100-04, Chapters 5 and 6 to Provide Language-Only Changes for Updating ICD-10, ASC X12, and Medicare Administrative Contractor (MAC) Implementation – Rescinded and replaced by Transmittal 3220	09/16/2014	8524
R2899CP	03/07/2014	Pub 100-04, Language Only Update for Chapters Five and Six for Conversion to ICD- 10 - Rescinded and replaced by Transmittal 3028	10/01/2014	8524
R2868CP	02/06/2014	Therapy Modifier Consistency Edits	07/07/2014	8556
R2859CP	01/17/2014	Applying the Therapy Caps to Critical Access Hospitals	01/31/2014	8426
R2844CP	12/27/2013	2014 Annual Update to the Therapy Code List	01/06/2014	8482
R2809CP	11/06/2013	2014 Annual Update to the Therapy Code List – Rescinded and replaced by Transmittal 2844	01/06/2014	8482
R2783CP	09/10/2013	Corrections to the Medicare Claims Processing Manual	09/17/2013	8343

R2736CP	06/28/2013	Billing Social Work and Psychological Services in Comprehensive Outpatient	10/07/2013	8257

Rev #	Issue Date	Subject	Impl Date	CR#
		Rehabilitation Facilities (CORFs)		
R2725CP	06/14/2013	Corrections to the Medicare Claims Processing Manual – Rescinded and replaced by Transmittal 2783	09/17/2013	8343
R2690CP	05/03/2013	Billing Social Work and Psychological Services in Comprehensive Outpatient Rehabilitation Facilities (CORFs) – Rescinded and replaced by Transmittal 2736	10/07/2013	8257
R2622CP	12/21/2012	Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle-Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012	01/07/2013	8005
R2615CP	12/14/2012	Revisions of the Financial Limitation for Outpatient Therapy Services-Section 3005 of the Middle-Class Tax Relief and Job Creation Act of 2012	10/01/2012	7785
R2603CP	11/30/2012	Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 – Rescinded and replaced by Transmittal 2622	01/07/2013	8005
R2537CP	08/31/2012	Expiration of 2012 Therapy Cap Revisions and User-Controlled Mechanism to Identify Legislative Effective Dates	01/07/2013	7881
R2532CP	08/24/2012	Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 – Rescinded and replaced by Transmittal 2603	01/07/2013	8005

R2457CP	04/27/2012	Revisions of the Financial Limitation for	10/01/2012	7785

Rev #	Issue Date	Subject	Impl Date	CR#
		Outpatient Therapy Services-Section 3005 of the Middle-Class Tax Relief and Job Creation Act of 2012 – Rescinded and replaced by Transmittal 2615		
R2328CP	10/27/2011	Claim Adjustment Reason Code (CARC) Used for Therapy Claims Subject to the Multiple Procedure Payment Reduction	04/02/2012	7564
R2160CP	02/18/2011	Correction to Manual References in Chapter 5, Section 20.2	05/19/2011	7315
R2121CP	12/17/2010	Reporting of Service Units With HCPCS	03/21/2011	7247
R2091CP	11/12/2010	Correct Reporting of Modifiers and Revenue Codes on Claims for Therapy Services	04/04/2011	7170
R2073CP	10/22/2010	Therapy Cap Values for Calendar Year (CY) 2011	01/03/2011	7107
R2055CP	09/17/2010	Therapy Cap Values for Calendar Year (CY) 2011 – Rescinded and replaced by Transmittal 2073	01/03/2011	7107
R2044CP	09/03/2010	Revisions and Re-issuance of Audiology Policies	09/30/2010	6447
R2007CP	07/23/2007	Revisions and Re-issuance of Audiology Policies – Rescinded and replaced by Transmittal 2044	08/11/2010	6447
R1985CP	06/11/2010	Clarifications and Updates of Therapy Services Policies	07/11/2010	6980
R1975CP	05/28/2010	Revisions and Re-issuance of Audiology Policies - Rescinded and replaced by Transmittal 2007	07/28/2010	6447
R1951CP	04/27/2010	Removal of the Provider Reporting Requirement for Total Number of Therapy	10/04/2010	6899

Rev #	Issue Date	Subject	Impl Date	CR#
		Visits Using Value Codes 50-53		
R1921CP	02/19/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)	04/05/2010	6563
R1894CP	01/15/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1921	04/05/2010	6563
R1876CP	12/18/2009	Coverage of Kidney Disease Patient Education Services	04/05/2010	6557
R1860CP	11/20/2009	Therapy Cap Values for Calendar Year (CY) 2010	01/04/2010	6660
R1851CP	11/13/2009	Therapy Cap Values for Calendar Year (CY) 2010 – Rescinded and replaced by Transmittal 1860	01/04/2010	6660
R1850CP	11/13/2009	2010 Annual Update to the Therapy Code List	01/04/2010	6719
R1843CP	10/30/2009	Outpatient Mental Health Treatment Limitation	01/04/2010	6686
R1840CP	10/29/2009	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1894	04/05/2010	6563
R1733CP	05/08/2009	Manual Clarification for Skilled Nursing Facility (SNF) and Therapy Billing	04/27/2009	6407
R1717CP	04/24/2009	Speech-Language Pathology Practice Payment Policy	07/06/2009	6381
R1706CP	03/27/2009	Manual Clarification for Skilled Nursing Facility (SNF) and Therapy Billing – Rescinded and replaced by Transmittal 1733	04/27/2009	6407

Monthly Billing

Rev #	Issue Date	Subject	Impl Date	CR#
R1678CP	02/13/2009	Outpatient Therapy Caps With Exceptions in CY 2009	04/06/2009	6321
R1631CP	11/07/2008	Extension of Therapy Cap Exception Process	12/08/2008	6222
R1593CP	09/12/2008	Smoking and Tobacco Use Cessation Counseling Billing Update for Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Physical Therapy Providers (OPTs)	12/12/2008	6163
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1459CP	02/22/2008	Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for Fiscal Year (FY) 2008	07/07/2008	5898
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1414CP	01/17/2008	Outpatient Therapy Caps Without KX Modifier Exceptions Start January 1, 2008	01/07/2008	5871
R1407CP	01/10/2008	Outpatient Therapy Caps Without KX Modifier Exceptions Start January 1, 2008 – Replaced by Transmittal 1414	01/07/2008	5871
R1377CP	11/23/2007	2008 Annual Update to the Therapy Code List	01/07/2008	5810
R1183CP	02/09/2007	Infrared Therapy Devices	01/16/2007	5421
R1145CP	12/29/2006	Outpatient Therapy Cap Exceptions Process for Calendar Year (CY) 2007	01/29/2007	5478
R1127CP	12/15/2006	Infrared Therapy Devices – Replaced by Transmittal 1183	01/16/2007	5421
R1106CP	11/09/2006	Outpatient Therapy Cap Clarifications	12/09/2006	5271

Rev #	Issue Date	Subject	Impl Date	CR#
R1019CP	08/03/2006	Outpatient Therapy - Additional DRA Mandated Service Edits	01/02/2007	5253
R1016CP	07/28/2006	Outpatient Therapy - Additional DRA Mandated Service Edit	01/02/2007	5253
R1000CP	07/19/2006	Common Working File (CWF) to the Medicare Beneficiary Database (MBD) Data Exchange Changes	10/02/2006	4300
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R908CP	04/21/2006	Common Working File (CWF) to the Medicare Beneficiary Database (MBD) Data Exchange Changes	10/02/2006	4300
R855CP	02/15/2006	Therapy Caps Exception Process	3/13/2006	4364
R853CP	02/13/2006	Therapy Caps Exception Process	3/13/2006	4364
R805CP	01/06/2006	Annual Update to the Therapy Code List	02/06/2006	4226
R771CP	12/02/2005	Revisions to Pub.100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier	01/03/2006	4181
R759CP	11/18/2005	Therapy Caps to be Effective January 1, 2006	01/03/2006	4115
R515CP	04/01/2005	Update to 100-04 and Therapy Code Lists	07/05/2005	3647
R463CP	02/04/2005	Update to 100-04 and Therapy Code Lists	07/05/2005	3647
R319CP	10/22/2004	CORF/OPT Edit for Billing Inappropriate Supplies	04/04/2005	3468
R042CP	12/08/2003	The Financial Limitation on Therapy Services	12/08/2003	3005

Rev #	Issue Date	Subject	Impl Date	CR#
R03OCP	11/14/2003	The Financial Limitation on Therapy Services	01/05/2004	2973
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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ICD-10

An Introduction to ICD-10

The International Classification of Disease, Version 9 (ICD-9) was utilized for over 30 years for a number of assignments in the American Healthcare system. These uses include reimbursement, payer contracts and coverage determinations, assessment of provider performance with disease management, and monitoring utilization patterns. The International Classification of Disease has also been utilized for providing criteria for inpatient care vs. outpatient services, tracking the severity of illness data including mortality and complications, as well as public health tracking and reporting.

The ICD-9 system lacked room for expansion for new diagnoses, included outdated language, a lack of specificity and had an inability to provide details necessary to measure the acuity level of patients or their continuum of care. Specifically, the system required multiple codes for some diseases and manifestations with no ability to show relationships or co-morbidities impacting care.

ICD-10:

As of October 1, 2015, all HIPAA entities were required to implement a new code set, International Classification of Disease, Version 10. With the utilization of ICD-10 providers will see combination diagnosis/symptom codes that reduce the number of codes needed to describe a condition. ICD-10 also includes expanded injury codes, an incorporation of common 4^{th} and 5^{th} digit sub-classifications as well as an additional 6^{th} and 7^{th} character. ICD-10 will allow providers increased specificity in code assignment and will have the potential for further expansion that was not possible with ICD-9.

The increased specificity will allow monitoring of resource utilization across the continuum of care, it will reduce the number of claims miscoded, rejected, or improperly reimbursed and will assist in identifying and preventing fraud and abuse. ICD-10 also aims to improve clinical, financial, and administrative performance, and allow data review and comparison to be expanded outside of the United States to include international data.

ICD-10 has 3 to 7 digits compared to a maximum of 5 digits with ICD-9. The first three digits identify the disease major category, the next three digits represent the etiology, anatomic site and severity of the code. The last digit is the extension code used to identify information pertaining to the episode of care.

Codes will include the following format:

- Digit 1 is alpha (A→Z, not case sensitive)
- Digit 2 is numeric
- Digit 3 is alpha (not case sensitive) or numeric
- Digits 4→7 are alpha (not case sensitive) or numeric
- "X" is used a placeholder for codes that contain fewer than 6 characters and a 7th character is required

The following sites will assist providers in locating the appropriate ICD-10 code for coding and billing purposes.

- http://apps.who.int/classifications/icd10/browse/2016/en

CPT Codes

Medicare and the AMA have established rules for using specific CPT codes. The Medicare rule always supersedes the AMA rule when billing Medicare.

CPT Modifiers

Most CPT codes represent "typical" visit lengths or times to conduct a typical test unless the time is specified in the CPT descriptor. For significantly atypical procedures, a **modifier "-22"** can be used to indicate much longer than normal procedures and a **"-52" modifier** for an abbreviated procedure. Modifier "-22" should not be used frequently because a fiscal intermediary or carrier could make the determination that the procedure reflects typical service delivery. **Modifier "-59"** is used to establish one procedure as distinct from another procedure billed on the same day. For claims with the -22 modifier, a description of the need for extended services should accompany the claim.

CPT / G-Codes

Healthcare Coding Systems for Rehabilitation Services

Coding System	CPT	HCPCS (Level II)	ICD-9-CM
Full Title	Current Procedural Terminology	Healthcare Common Procedure Coding System	International Classification of Diseases, 9th edition, Clinical Modification
Purpose	Reporting healthcare procedures or services	Reporting supplies, equipment, devices and some procedures	Reporting diagnoses, disorders, conditions and symptoms
Maintained By:	American Medical Assn.	Centers for Medicare and Medicaid Services	National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services
Code Type	Five digits (e.g., 92507)	Alphanumeric (e.g., V5244)	Tabular list is organized by 3 numeric digit codes; payers expect code to be carried to the 5th digit (e.g., 784.61) when available; includes supplemental alphanumeric V-codes to report purpose of visit & factors influencing health status
Link	www.amaassn.org/ama/pub/category/3113.html	http://www.cms.hhs.gov/MedHCPCSGenInfo/	www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm
Modifiers	Many available (e.g., -22 when the service is greater than usual)	Available and may apply to Medicare Level I HCPCS (e.g., -GN for "services delivered under an outpatient speech-language pathology plan of care)	Not Applicable
Comments	Most therapy services and procedures not time-based; many be referred to as HCPCS Level I	HCPCS Level II codes are for reporting supplies, equipment (e.g., hearing aids & AAC devices) & some procedures; screening codes not accepted by Medicare; may include temporary codes	Procedural V-codes not accepted by payers; do not confuse ICD-9-CM V-codes (diagnoses) with HCPCS V-codes (audiology-related devices and screening procedures); ICD-9 CM V-codes may be primary diagnosis (e.g., V57.3, encounter with speech-language pathologist)

CPT / G-Codes

Definitions

(American Medical Association – CPT 2000 Professional Addition, pages 420-422 and pages 447-450)

Speech Pathology

92521 Evaluation of speech fluency (e.g., stuttering, cluttering)

92522 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)

92523 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)

92524 Behavioral and qualitative analysis of voice and resonance - See more at: http://www.asha.org/Practice/reimbursement/coding/New-CPT-Evaluation-Codes-for-SLPs/#sthash.peUpI4xr.dpuf

92507 Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual

92508 group, two or more individuals

92510 Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming

92511 Nasopharyngoscopy with endoscope (separate procedure)

Physical and Occupational Therapy

97001 Physical therapy evaluation

97002 Physical therapy re-evaluation

97003 Occupational therapy evaluation

97004 Occupational therapy re-evaluation

97010	Application of a modality to one or more areas; hot or cold packs
97012	Traction, mechanical
97014	Electrical stimulation (unattended)
97016	Vasopneumatic devices
97018	Paraffin bath
97020	Microwave
97022	Whirlpool
97024	Diathermy
97026	Infrared
97028	Ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Iontophoresis, each 15 minutes
97034	Contrast baths, each 15 minutes
97035	Ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
97113	Aquatic therapy with therapeutic exercise
97116	Gait training (includes stair climbing)

97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97760	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
97761	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one-on-one contact by provider, each 15 minutes
97542	Wheelchair management/propulsion training, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening each additional hour (List separately in addition to code for primary procedure)
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes

97770 (Deleted code) Development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct (one-on-one) patient contact by the provider, each 15 minutes

97532 Cognitive Rehabilitation

CPT / G-Codes

Medicare Coding Rules for Speech-Language Pathologists
Note many third party payers selectively adopt Medicare coding rules

Code	Descriptor	Special Rules/Notes
92507	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Includes training & modification of voice prosthetics. Medicare directs SLPs to use 92507 for auditory rehabilitation.
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); **with** evaluation of language comprehension and expression (e.g., receptive and expressive language)	**New Code**, replaces 92506 effective January 1, 2014. For evaluation of language only, apply a modifier -52.
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)	Use modifier -52 if only one test is performed (i.e., aerodynamic testing only, acoustic testing only.
92524	Behavioral and qualitative analysis of voice and resonance - See more at: http://www.asha.org/Practice/reimbursement/coding/New-CPT-Evaluation-Codes-for-SLPs/#sthash.peUpI4xr.dpuf	**New code**, replaces 92506 effective January 1, 2014
92526	Treatment of swallowing dysfunction and/or oral function for feeding	There is no dysphagia group therapy code. Several intermediaries specify 92508 in dysphagia LCDs.
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Under Medicare, applies to tracheoesophageal prostheses, artificial larynges, as well as voice amplifiers. Use 92507 for training and modification of voice prostheses.
92607	Evaluation for prescription of speech-generating AAC device (SGD), first hour	SGDs generate synthesized or digital speech. Include -52 modifier if less than one hour.
92608	SGD evaluation (92607), each additional 30 minutes	May be reported on ensuing days until the evaluation is completed.
92609	Therapeutic services for use of speech-generating device, including programming and modification	
92610	Evaluation of oral and pharyngeal swallowing function	

Code	Descriptor	Special Rules/Notes
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (FEES)	This is the complete endoscopic procedure. Level of physician supervision varies by state. Use 92700 if performed without cine or video recording.
92616	Flexible fiberoptic endoscropic evaluation of swallowing and laryngeal sensory testing by cine or video recording (FEESST)	This is the complete endoscopic procedure for swallowing and sensory testing combined. Level of physician supervision varies by state.
92626	Evaluation of auditory rehabilitation status, first hour	
92627	Evaluation of auditory rehabilitation status, each additional 15 minutes	See Medically Unlikely Edits for restrictions on multiple billings.
92630	Auditory rehabilitation; pre-lingual hearing loss	SLPs must use 92507 in lieu of this code
92633	Auditory rehabilitation; post-lingual hearing loss	SLPs must use 92507 in lieu of this code
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing; e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	There is no firm rule regarding time necessary to qualify for subsequent one-hour codes. Recommend use of -52 modifier if less than 30 minute segment.
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes	15 minute rule: see at end of table Cannot report 97532 if report 92507 on same day.

For CPT codes designated as 15 minutes, multiple coding represents minimum face-to-face treatment, as follows:

1 unit:	8 minutes to <23 minutes
2 units:	23 minutes to <38 minutes
3 units :	38 minutes to <53 minutes
4 units:	53 minutes to <68 minutes
5 units:	68 minutes to <83 minutes
6 units:	83 minutes to <98 minutes

Untimed codes: If the CPT descriptor has no time designation, the procedure is billed as a session without regard to time.

Code modifiers: -52 or -22 can be appended to the CPT code to indicate that the session was unusually short or long, respectively. The payer has the option to adjust the payment accordingly. If either of these modifiers are used too often, the payer may consider the incidence to not be "unusual." **For restrictions on certain CPT code pairs billed on the same day, see the CCI tables.**

Source: American Speech-Language-Hearing Association (ASHA)

HCPCS Coding Requirement

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The current Healthcare Common Procedure Coding System/Current Procedural Terminology is used for the reporting of these services. The uniform coding requirement in the Act is specific to payment for all CORF services and outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology - that is provided and billed to carriers and fiscal intermediaries (FIs). The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the non-facility rate.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS/CPT for outpatient rehabilitation and CORF services began using HCPCS to report these services. This requirement does not apply to outpatient rehabilitation services provided by:

- Critical access hospitals, which are paid on a cost basis, not MPFS;
- RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or
- Providers that do not furnish therapy services.

The following "providers of services" must bill the FI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A1 stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A1 stay and to nonresidents who receive outpatient rehabilitation services from the SNF);
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care2 (POC);
- Comprehensive outpatient rehabilitation facilities (CORFs); and
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient physical therapy facilities in this instruction).

Note 1. The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

Note 2. For HHAs, HCPCS/CPT coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a Home Health plan of care.

The following practitioners must bill the carriers for outpatient rehabilitation therapy services using HCPCS/CPT codes:

- Physical therapists in private practice (PTPPs),
- Occupational therapists in private practice (OTPPs),
- Physicians, including MDs, DOs, podiatrists and optometrists, and
- Certain nonphysician practitioners (NPPs), acting within their State scope of practice, e.g., nurse practitioners and clinical nurse specialists.

Providers billing to intermediaries shall report:

- The date the therapy plan of care was either established or last reviewed (see §220.1.3B) in Occurrence Code 17, 29, or 30.
- The first day of treatment in Occurrence Code 35, 44, or 45.

Applicable Outpatient Rehabilitation HCPCS Codes

The CMS identifies the following codes as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech-language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology. Check the notes below the chart for details about each code.

When in effect, any financial limitation will also apply to services represented by the following codes, except as noted below.

NOTE: Listing of the following codes does not imply that services are covered or applicable to all provider settings.

HCPCS Code	Description
64550	Apply neurostimulator
90901	Biofeedback train, any method
92506	Speech and hearing evaluation
92507	Speech and hearing therapy
92508	Speech and hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92605	Eval for non-speech device rx
92606	Non-speech device service
92607	Ex for speech device rx, 1 hr.
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
62611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
96105	Assessment of aphasia
96110	Developmental test, limb

96111	Developmental test, extend
96125	Cognitive test by hc pro
97001	PT evaluation
HCPCS Code	Description
97002	PT re-evaluation
97003	OT evaluation
97004	OT re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy; i.e., microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self-care management training
97537	Community/work reintegration
97542	Wheelchair management training
97597	Active wood care/20 cm or <
97598	Active wound care > 20 cm
97602	Wound(s) care non-selective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97750	Physical performance test

97755	Assistive technology assess
97760	Othotic management and training
97761	Prosthetic training
97762	Checkout for orthotic/prosthetic use
97799	Physical medicine procedure
G0281	Elec stim unattended for press
G0283	Elec stim other than wound
HCPCS Code	Description
G0329	Electromagnetic tx for ulcers
0019T	Extracorp shock wv tx, mx nos
0029T	Magnetic tx for incontinence

CPT / G-Codes

Background

In 2011, more than 8 million Medicare beneficiaries received outpatient therapy services, including physical therapy (PT), occupational therapy (OT), and speech-language-pathology (SLP). Medicare payments for these services exceeded $5.8 billion.

Between 1998-2008, Medicare expenditures for outpatient therapy services increased at a rate of 10.1% per year, while the number of Medicare beneficiaries receiving therapy services only increased by 2.9% per year.

Efforts have been focused on developing Medicare payment incentives that encourage delivery of reasonable and necessary care while discouraging overutilization of therapy services and the provisions of medically unnecessary care.

CMS Rationale

The Center for Medicare and Medicaid Services (CMS) has been ardently trying to collect data on patient function during the course of outpatient therapy, in order to better understand patient outcomes and develop a reimbursement system that is appropriate for the services rendered.

Section 3005(g) of the MCTRJCA (Middle Class Tax Relief and Job Creation Act of 2012) requires CMS to implement, beginning on January 1, 2013 "…a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Act. Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes."

Program Goal

The long-term goal is to develop an improved payment system for Medicare therapy services.

The desired payment system would pay appropriately and similarly for efficient and effective services furnished to beneficiaries with similar conditions and functional limitations that have potential to benefit from the services furnished.

Data on Medicare beneficiaries' use and outcomes from therapy services does not exist. The goal is to identify gaps in information and determine what additional data would be needed to develop a new payment policy.

Without understanding the diversity of beneficiaries and types/volume of treatment provided, information is insufficient to develop an improved payment policy.

CPT / G-Codes

Overview

The G-Code system is made up of **14 functional limitations** from which PT, OT and ST can choose. Once a limitation is chosen, the therapists will then choose a **modifier for the G-Code from a 7-point Likert scale to indicate the degree of impairment.** This scale was developed based on four standardized tests, the Post-Acute Care (AM-PAC) tool, the FOTO Patient Inquiry, OPTIMAL, and NOMS. CMS stressed that it is not necessary for therapists to use these standardized tests in their assessment process, but that they should find a way to measure patient performance that will easily translate into the G-Code modifiers.

In addition to requiring G-Codes on the UB-04, these codes will need to be recorded in the medical record. Therapy departments should use the testing period to investigate efficient processes for recording these codes on the therapy documentation. Likewise, software vendors should be contacted to ensure they will be incorporating G-Codes into their systems.

Functional Reporting will begin a 6-month testing period January 1 through June 30, 2013. Functional reporting will be required in claims **throughout the entire episode** of care for dates of service on or after **July 1st, 2013**.

Only one functional limitation shall be reported at a time per therapy discipline. Claims will be returned/rejected without applicable G-Codes and modifiers for dates of services on or after **July 1st, 2013.**

Applicable providers are outpatients (OPs) and inpatients (IPs) providing Part B therapy services:

- Medicare Part B provided in a Skilled Nursing Facility (SNF)
- Therapists in Private Practice: Physical Therapists, Occupational Therapists and Speech Language Pathologists
- Physicians: Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctors of Podiatric Medicine (DPMs) and Doctors of Optometry (ODs)
- Rehabilitation Agencies
- Home Health Agencies (HHAs)
- CORFs
- Outpatient Hospitals (including Emergency Departments)
- Critical Access Hospitals
- NPPs: Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and Physician Assistants (PAs)

CPT / G-Codes

Therapy Functional Reporting Timing

Each date of service will always include **2 G-Codes**

- On Evaluation
  - Current and Goal Status
- Progress – **On or prior** to 10th visit
  - Current and Goal Status
- Discharge
  - Goal and Discharge Status
- The exception is:
  - At the time reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary (i.e., before reporting on a different functional limitation begins)
  - At the time reporting is begun on a different (second, third, etc.) functional limitation within the same episode of care

Evaluation Codes

- PT Evaluation defined by billing the following Physical Therapy CPT codes:
  - 97001 Physical Therapy Evaluation
  - 97002 Physical Therapy Re-evaluation
- OT Evaluation defined by billing the following Occupational Therapy CPT codes:
  - 97003 Occupational Therapy Evaluation
  - 97004 Occupational Therapy Re-evaluation
- Evaluation defined by billing the following Speech Therapy CPT codes:
  - 92506 Speech Evaluation
  - 92610 Swallow Evaluation
  - 92597 Voice Prosthesis Evaluation
  - 96105 Assessment of Aphasia
  - 92607/92608 Speech Generating Device Evaluation
  - 92611 Motor Fluoroscopic Evaluation of Swallow

- 92612/92614/92616 FEES evaluation

There are 42 functional G-Codes that are combined in 14 sets of three codes each. Six of the G-Code sets are used for PT and OT functional limitations, while eight of the G-Code sets are for SLP functional limitations.

The clinician must select the G-Code set for the functional limitation. Selection of the G-Code should reflect primary functional limitation, the predominant limitation that the furnished therapy services are intended to address:

- Most clinically relevant to the successful outcome for the beneficiary
- The one that would yield the quickest and/or greatest functional progress
- The one that is the greatest priority for the beneficiary

Each of the 14 Goal sets have 3 codes within the set:

- Current status
- Goal status
- Discharge status

For each functional G-Code, use a modifier to report the severity/complexity for that functional limitation. In other words, the clinical status of the patient will be reported to CMS through the billing process.

Modifiers are lettered by severity (H, I, J, K, L, M, N) where H = no impairment and N = 100% impairment.

Functional modifier selection is based on the clinical judgment of the therapist, who is required to document this information in the patient's medical record.

Therapist will have an option to utilize "Other Functional Code" when one of the categorical code sets does not describe the beneficiary's functional limitation as follows:

- A beneficiary's functional limitation that is not defined by one of four categories
- A beneficiary whose therapy services are not intended to treat a functional limitation
- A beneficiary's functional limitation where an overall, composite, or other score from a functional assessment tool is used and does not clearly represent a functional limitation

A second functional limitation will be reported for some beneficiaries. When the beneficiary has reached his or her goal or progress has been maximized on the initially reported functional limitation, but the need for treatment continues, reporting is required for a second functional

limitation using another set of G-Codes, therefore, reporting on more than one functional limitation may be required for some patients, but not simultaneously.

Therapy Functional Reporting Examples (Mobility):

- 12.1 Evaluation
  - G8978GPCM Mobility current status
  - G8979GPCH Mobility goal status

  Must be reported for all evaluation codes

- 12.15 On or Before 10th visit
  - G8978GPCK Mobility current status
  - G8979GPCH Mobility goal status

  Must be reported on or before the 10th treatment.
  Corresponding documentation in the medical record to match billing.

- 12.24 Discharge
  - G8980GPCH Mobility discharge status
  - G8979GPCH Mobility goal status

  Must be reported at Discharge
  Discharge assessment should match the G-Code reflected on the bill

G-Codes for Claims-Based Functional Reporting

Mobility: Walking & Moving Around	
G8978	Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals.
G8979	Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
G8980	Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting.
Changing & Maintaining Body Position	
G8981	Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals.
G8982	Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
G8983	Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting.
Carrying, Moving & Handling Objects	
G8984	Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals.
G8985	Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
G8986	Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting.
Self Care	
G8987	Self-care functional limitation, current status, at therapy episode outset and at reporting intervals.
G8988	Self-care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
G8989	Self-care functional limitation, discharge status, at discharge from therapy or to end reporting.
Other PT/OT Primary Functional Limitation	
G8990	Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals.
G8991	Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
G8992	Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting.

G-Codes for Claims-Based Functional Reporting

Other PT/OT Subsequent Functional Limitation	
G8993	Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals.
Other PT/OT Primary Functional Limitation	
G8994	Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
G8995	Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting.
Swallowing	
G8996	Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G8997	Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy.
G8998	Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation.
Motor Speech	
G8999	Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G9157	Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy.
G9158	Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation.
Spoken Language Comprehension	
G9159	Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G9160	Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy.
G9161	Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation.
Spoken Language Expression	
G9162	Spoken language expression functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G9163	Spoken language expression functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy.
G9164	Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation.

G-Codes for Claims-Based Functional Reporting

Attention	
G9165	Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G9166	Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy.
G9167	Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation.
Memory	
G9168	Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G9169	Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy.
G9170	Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation.
Voice	
G9171	Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G9172	Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy.
G9173	Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation.
Other SLP Functional Limitation	
G9174	Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals.
G9175	Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy.
G9176	Other speech language pathology functional limitation, discharge status at discharge from therapy/end of reporting on limitation.

Severity/Complexity Modifiers

Modifier	Impairment limitation restriction
CH	0 percent impaired, limited or restricted.
CI	At least 1 percent but less than 20 percent impaired, limited or restricted.
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted.
CK	At least 40 percent but less than 60 percent impaired, limited or restricted.
CL	At least 60 percent but less than 80 percent impaired, limited or restricted.
CM	At least 80 percent but less than 100 percent impaired, limited or restricted.
CN	100 percent impaired, limited or restricted.

CPT / G-Codes

Physical/Occupational Therapy Functional Reporting G-Codes

Patient Last Name: _____ First Name:_____

☐ Physical Therapy ☐ Occupational Therapy

☐ Initial Reporting ☐ Progress Reporting ☐ Interim ☐ Discharge Reporting

Long-Term Goal:

Functional Reporting Category (Select Only One):

Discharge Status

Mobility: Walking & Moving Around	Modifier	Changing & Maintaining Body Position	Modifier	Carrying, Moving & Handling Objects	Modifier	Self Care	Modifier
G8978, Mobility Current		G8981 Position Current		G8984 Carrying Current		G8987 Self Care Current	
G8979, Mobility Goal		G8982 Position Goal		G8985 Carrying Goal		G8988 Self Care Goal	
G8980, Mobility Discharge		G8983 Position Discharge		G8986 Carrying Discharge		G8989 Self Care Discharge	
Other Physical or Occupational Primary		PT/OT Subsequent		Reporting Method Utilized			
G8990 Other PT/OT Current		G8993 Subsequent Current		Outcome Measurement Tool Utilized for Reporting:			
G8991 Other PT/OT Goal		G8994 Subsequent Goal		Score:			
G8992 Other PT/OT Discharge		G8995 Subsequent Discharge		Clinical Status:			

Comments:

CH 0 % **CI** At least 1 % but less than 20 % **CJ** At least 20 % but less than 40 %
CK At least 40 % but less than 60 % **CL** At least 60 % but less than 80 %
CM At least 80 % but less than 100 **CN** 100 %

Signature/Title:_____
Date:_____

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-3738
www.harmony-healthcare.com

G-Coding for Functional Activities

Functional Activity Levels of Assist

Assist	Description	% Impairment
Dependent / Total Assistance	Therapist provides 100% of physical output needed for task, patient does 0%.	100% Impairment: CN
Maximum Assistance	Therapist provides 75% of physical output needed for task, patient does 25% of work.	80 – 99% Impairment: CM
Moderate Assistance	Therapist provides 50% of physical output needed for task, patient does 50% of work.	60 – 79% Impairment: CL
Minimal Assistance	Therapist provides 25% of physical output needed for task; patient does 75% of work.	40 – 59% Impairment: CK
Contact Guard Assistance	Therapist is in contact with patient via gait belt, just in case physical assistance is needed.	20 – 39% Impairment: CJ
Supervision/ Stand By Assistance	Therapist is needed for supervision for safety and performance specifics.	1 – 19% Impairment: CI
Independent	No physical or cognitive assistance required.	0% Impairment: CH

Power Wheelchair Mobility Levels of Assist

Assist	% Impairment
Unable to mobilize power wheelchair	100% Impairment: CN
Able to mobilize power wheelchair with max assist	80 – 99% Impairment: CM
Able to mobilize power wheelchair with mod assist	60 – 79% Impairment: CL
Able to mobilize power wheelchair with min assist	40 – 59% Impairment: CK
Able to mobilize power wheelchair with supervision in large indoor spaces. Able to propel wheelchair with verbal cuing and physical assist in bedroom and on/off elevators	20 – 39% Impairment: CJ
Able to independently mobilize power wheelchair in large indoor spaces and enclosed outdoor courtyards. May require physical assist on/off elevators	1 – 19% Impairment: CI
Able to independently mobilize power wheelchair in small and large spaces, indoors and out, as well as on/off elevators	0% Impairment: CH

Changing and Maintaining Body Positioning: Repositioning

Frequency of Staff Assistance	% Impairment
Patient's current seated position in wheelchair is causing pain, skin breakdown, or respiratory distress 100% of the time patient is seated	100% Impairment: CN
Patient requires physical assist at least once an hour, as patient is unable to maintain a position that protects him or her from pain, skin breakdown, or respiratory distress	80 – 99% Impairment: CM
Patient requires physical assist to reposition in wheelchair once in a 2-hour period, as patient occasionally maneuvers out of a position that protects him or her from pain, skin breakdown, or respiratory distress	60 – 79% Impairment: CL
Patient requires physical assist to reposition in wheelchair once in a 4-hour period, as patient occasionally maneuvers out of a position that protects him or her from pain, skin breakdown, or respiratory distress	40 – 59% Impairment: CK
Patient requires physical assist to reposition in wheelchair once in a 6-hour period, as patient occasionally maneuvers out of a position that protects him or her from pain, skin breakdown, or respiratory distress	20 – 39% Impairment: CJ
Patient requires verbal cues to reposition in wheelchair once or twice in a 6-hour period, as patient occasionally maneuvers out of a position that protects him or her from pain, skin breakdown, or respiratory distress	1 – 19% Impairment: CI
Patient is free from pain, respiratory distress, and s/s skin breakdown while seated in wheelchair for 6 or more hours without staff assistance	0% Impairment: CH

Changing and Maintaining Body Positioning: Head, Neck, and Spine

Frequency of Staff Assistance	% Impairment
Patient is seated with head, neck, and spine 96 – 100% off midline. Patient likely voices or demonstrates 8 – 10/10 generalized pain. Patient may also demonstrate signs of skin breakdown.	100% Impairment: CN
Patient is seated with head, neck, **and/or** spine 76 – 95% off midline. Patient likely voices or demonstrates 8 – 10/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	80 – 99% Impairment: CM
Patient is seated with head, neck, **and/or** spine 51 – 75% off midline. Patient likely voices or demonstrates 6 – 8/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	60 – 79% Impairment: CL
Patient is seated with head, neck, **and/or** spine 26 – 50% off midline. Patient likely voices or demonstrates 4 – 6/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	40 – 59% Impairment: CK
Patient is seated with head, neck, **and/or** spine 10 – 25% off midline. Patient may also voice or demonstrate 2 – 4/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	20 – 39% Impairment: CJ
Patient is seated with head, neck, **and/or** spine up to 10% off midline. Patient likely does not voice pain, discomfort, or demonstrate signs of skin breakdown.	1 – 19% Impairment: CI
Patient is seated upright with head, neck, and spine in midline. Patient is free from pain and skin breakdown.	0% Impairment: CH

Changing and Maintaining Body Positioning: Hips, Knees, and Ankles

Frequency of Staff Assistance	% Impairment
Patient is seated with hips, knees, **and** ankles 96 – 100% off neutral position. Patient likely voices or demonstrates 8 – 10/10 generalized pain. Patient may also demonstrate signs of skin breakdown.	100% Impairment: CN
Patient is seated with hips, knees, **and/or** ankles 76 – 95% off neutral position. Patient likely voices or demonstrates 8 – 10/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	80 – 99% Impairment: CM
Patient is seated with hips, knees, **and/or** ankles 51 – 75% off neutral position. Patient likely voices or demonstrates 6 – 8/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	60 – 79% Impairment: CL
Patient is seated upright with hips, knees, **and/or** ankles 26 – 50% off neutral position. Patient likely voices or demonstrates 4 – 6/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	40 – 59% Impairment: CK
Patient is seated with hips, knees, **and/or** ankles 10 – 25% off neutral position. Patient may also voice or demonstrate 2 – 4/10 pain in a targeted area(s). Patient may also demonstrate signs of skin breakdown.	20 – 39% Impairment: CJ
Patient is seated with hips, knees, **and/or** ankles up to 10% off neutral position. Patient likely does not voice pain, discomfort, or demonstrate signs of skin breakdown.	1 – 19% Impairment: CI
Patient is seated with hips, knees, **and/or** ankles in neutral position (90° flexion at hips, knees, and ankles). Patient is free from pain and skin breakdown.	0% Impairment: CH

G-Coding for Cognition

Safety

Level of Cueing	% Impairment
Patient requires verbal, tactile, and visual cues during 100% of the activity	100% Impairment: CN
Patient requires 3 forms of cuing during 80 – 90% of the activity	80 – 99% Impairment: CM
Patient requires 2 out of 3 forms of cuing during 75% of the activity	60 – 79% Impairment: CL
Patient requires 2 out of 3 forms of cuing during 50% of the activity	40 – 59% Impairment: CK
Patient requires 1 out of 3 forms of cuing during 25% of the activity	20 – 39% Impairment: CJ
Patient requires 1 out of 3 forms of cuing during 10 – 20% of the activity	1 – 19% Impairment: CI
Patient requires neither verbal, tactile, nor visual cues during 100% of the activity	0% Impairment: CH

Temporal Organization

Presentation	% Impairment
Patient requires max assist/cues for 4 out of 4 areas of task (initiation, continuation, sequencing, or termination)	100% Impairment: CN
Patient requires mod assist/cues for 2 - 3 out of 4 areas of task (initiation, continuation, sequencing, or termination)	80 – 99% Impairment: CM
Patient requires min assist/cues for 2 - 3 out of 4 areas of task (initiation, continuation, sequencing, or termination)	60 – 79% Impairment: CL
Patient requires min assist/cues for 1 - 2 out of 4 areas of task (initiation, continuation, sequencing, or termination)	40 – 59% Impairment: CK
Patient requires min assist/cues for 1 out of 4 areas of task (initiation, continuation, sequencing, or termination)	20 – 39% Impairment: CJ
Patient requires supervision/min cueing for 1 out of 4 areas of task (initiation, continuation, sequencing, or termination)	1 – 19% Impairment: CI
Patient independently initiates task, continues task, sequences task, and terminates task.	0% Impairment: CH

G-Coding for Range of Motion

Shoulder

Area	Normal Range	Actual Number of Total Degrees	% Impairment
Flexion	0 – 180	180	0%: CH
		144 – 179	1 – 19%: CI
		108 – 143	20 – 39%: CJ
		72 – 107	40 – 59%: CK
		36 – 71	60 – 79%: CL
		1 – 35	80 – 99%: CM
		0	100%: CN
Extension	0 – 60	60	0%: CH
		48 – 59	1 – 19%: CI
		36 – 47	20 – 39%: CJ
		24 – 35	40 – 59%: CK
		12 – 23	60 – 79%: CL
		1 – 11	80 – 99%: CM
		0	100%: CN
Ab/Adduction	0 – 180	180	0%: CH
		144 – 179	1 – 19%: CI
		108 – 143	20 – 39%: CJ
		72 – 107	40 – 59%: CK
		36 – 71	60 – 79%: CL
		1 – 35	80 – 99%: CM
		0	100%: CN
Internal Rotation	0 – 70	70	0%: CH
		56 – 69	1 – 19%: CI
		42 – 55	20 – 39%: CJ
		28 – 41	40 – 59%: CK
		14 – 27	60 – 79%: CL
		1 – 13	80 – 99%: CM
		0	100%: CN
External Rotation	0 – 90	90	0%: CH
		72 – 89	1 – 19%: CI
		54 – 71	20 – 39%: CJ
		36 – 53	40 – 59%: CK
		18 – 35	60 – 79%: CL
		1 – 17	80 – 99%: CM
		0	100%: CN

Elbow and Forearm

Area	Normal Range	Actual Number of Total Degrees	% Impairment
Flexion/Extension	0 – 150	150	0%: CH
		120 – 149	1 – 19%: CI
		90 – 119	20 – 39%: CJ
		60 – 89	40 – 59%: CK
		30 – 59	60 – 79%: CL
		1 – 29	80 – 99%: CM
		0	100%: CN
Supination	0 – 90	90	0%: CH
		72 – 89	1 – 19%: CI
		54 – 71	20 – 39%: CJ
		36 – 53	40 – 59%: CK
		18 – 35	60 – 79%: CL
		1 – 17	80 – 99%: CM
		0	100%: CN
Pronation	0 – 90	90	0%: CH
		72 – 89	1 – 19%: CI
		54 – 71	20 – 39%: CJ
		36 – 53	40 – 59%: CK
		18 – 35	60 – 79%: CL
		1 – 17	80 – 99%: CM
		0	100%: CN

Wrist

Area	Normal Range	Actual Number of Total Degrees	% Impairment
Flexion	0 – 80	80	0%: CH
		64 – 79	1 – 19%: CI
		48 – 63	20 – 39%: CJ
		32 – 47	40 – 59%: CK
		16 – 31	60 – 79%: CL
		1 – 15	80 – 99%: CM
		0	100%: CN
Extension	0 – 70	70	0%: CH
		56 – 69	1 – 19%: CI
		42 – 55	20 – 39%: CJ
		28 – 41	40 – 59%: CK
		14 – 27	60 – 79%: CL
		1 – 13	80 – 99%: CM
		0	100%: CN
Ulnar Deviation	0 – 30	30	0%: CH
		24 – 29	1 – 19%: CI
		18 – 23	20 – 39%: CJ
		12 – 17	40 – 59%: CK
		6 – 11	60 – 79%: CL
		1 – 5	80 – 99%: CM
		0	100%: CN
Radial Deviation	0 – 20	20	0%: CH
		16 – 19	1 – 19%: CI
		12 – 15	20 – 39%: CJ
		8 – 11	40 – 59%: CK
		4 – 7	60 – 79%: CL
		1 – 3	80 – 99%: CM
		0	100%: CN

Hip

Area	Normal Range	Actual Number of Total Degrees	% Impairment
Flexion	0 – 120	120	0%: CH
		96 – 119	1 – 19%: CI
		72 – 95	20 – 39%: CJ
		48 – 71	40 – 59%: CK
		24 – 47	60 – 79%: CL
		1 – 23	80 – 99%: CM
		0	100%: CN
Extension	0 – 30	30	0%: CH
		24 – 29	1 – 19%: CI
		18 – 23	20 – 39%: CJ
		12 – 17	40 – 59%: CK
		6 – 11	60 – 79%: CL
		1 – 5	80 – 99%: CM
		0	100%: CN
Abduction	0 – 45	45	0%: CH
		36 – 44	1 – 19%: CI
		27 – 35	20 – 39%: CJ
		18 – 26	40 – 59%: CK
		9 – 17	60 – 79%: CL
		1 – 8	80 – 99%: CM
		0	100%: CN
Adduction	0 – 30	30	0%: CH
		24 – 29	1 – 19%: CI
		18 – 23	20 – 39%: CJ
		12 – 17	40 – 59%: CK
		6 – 11	60 – 79%: CL
		1 – 5	80 – 99%: CM
		0	100%: CN
Internal Rotation	0 – 45	45	0%: CH
		36 – 44	1 – 19%: CI
		27 – 35	20 – 39%: CJ
		18 – 26	40 – 59%: CK
		9 – 17	60 – 79%: CL
		1 – 8	80 – 99%: CM
		0	100%: CN
External Rotation	0 – 45	45	0%: CH
		36 – 44	1 – 19%: CI
		27 – 35	20 – 39%: CJ
		18 – 26	40 – 59%: CK
		9 – 17	60 – 79%: CL
		1 – 8	80 – 99%: CM
		0	100%: CN

Knee

Area	Normal Range	Actual Number of Total Degrees	% Impairment
Flexion/Extension	0 – 135	135	0%: CH
		108 – 134	1 – 19%: CI
		81 – 107	20 – 39%: CJ
		54 – 80	40 – 59%: CK
		27 – 53	60 – 79%: CL
		1 – 26	80 – 99%: CM
		0	100%: CN

Ankle

Area	Normal Range	Actual Number of Total Degrees	% Impairment
Dorsiflexion	0 – 20	20	0%: CH
		16 – 19	1 – 19%: CI
		12 – 15	20 – 39%: CJ
		8 – 11	40 – 59%: CK
		4 – 7	60 – 79%: CL
		1 – 3	80 – 99%: CM
		0	100%: CN
Plantar Flexion	0 – 50	50	0%: CH
		40 – 49	1 – 19%: CI
		30 – 39	20 – 39%: CJ
		20 – 29	40 – 59%: CK
		10 – 19	60 – 79%: CL
		1 – 9	80 – 99%: CM
		0	100%: CN
Inversion	0 – 35	35	0%: CH
		28 – 34	1 – 19%: CI
		21 – 27	20 – 39%: CJ
		14 – 20	40 – 59%: CK
		7 – 13	60 – 79%: CL
		1 – 6	80 – 99%: CM
		0	100%: CN
Eversion	0 – 15	15	0%: CH
		12 – 14	1 – 19%: CI
		9 – 11	20 – 39%: CJ
		6 – 8	40 – 59%: CK
		3 – 5	60 – 79%: CL
		1 – 2	80 – 99%: CM
		0	100%: CN

Cervical

Area	Normal Range	Actual Number of Total Degrees	% Impairment
Flexion	0 – 45	45	0%: CH
		36 – 44	1 – 19%: CI
		27 – 35	20 – 39%: CJ
		18 – 26	40 – 59%: CK
		9 – 17	60 – 79%: CL
		1 – 8	80 – 99%: CM
		0	100%: CN
Extension	0 – 70	70	0%: CH
		56 – 69	1 – 19%: CI
		42 – 55	20 – 39%: CJ
		28 – 41	40 – 59%: CK
		14 – 27	60 – 79%: CL
		1 – 13	80 – 99%: CM
		0	100%: CN
Rotation	0 – 60	60	0%: CH
		48 – 59	1 – 19%: CI
		36 – 47	20 – 39%: CJ
		24 – 35	40 – 59%: CK
		12 – 23	60 – 79%: CL
		1 – 11	80 – 99%: CM
		0	100%: CN
Lateral Flexion	0 – 40	40	0%: CH
		33 – 39	1 – 19%: CI
		25 – 32	20 – 39%: CJ
		17 – 24	40 – 59%: CK
		9 – 16	60 – 79%: CL
		1 – 8	80 – 99%: CM
		0	100%: CN

Functional Activity Tolerance

Grade	Description	% Impairment
Poor -	• Fatigue, dyspnea, or pain may be present on rest. • Standing tolerance is < 1 minute. • Patient is unable to ambulate.	100% Impairment: CN
Poor	• Comfortable at rest. Brief, non-resistive activity causes fatigue, dyspnea, or pain. • Standing tolerance is 1 – 3 minutes. • Patient can pivot transfer.	80 – 99% Impairment: CM
Poor +	• Tolerates 2 – 4 minutes non-resistive activity with frequent rests. • Standing tolerance is 2 – 4 minutes. • Patient can ambulate up to 25 feet.	60 – 79% Impairment: CL
Fair -	• Tolerates 2 – 4 minutes non-resistive activity with occasional rests. • Standing tolerance is 5 – 10 minutes. • Patient can ambulate up to 75 feet.	
Fair	• Tolerates light resistive activity 10 – 15 minutes with occasional rests. • Standing tolerance is 10 minutes. • Patient can ambulate up to 150 feet.	40 – 59% Impairment: CK
Fair +	• Tolerates light to moderate resistive activity 20 – 30 minutes and position changes with infrequent rest periods and minimal fatigue. • Standing tolerance is 15 minutes. • Patient can ambulate up to 225 feet.	20 – 39% Impairment: CJ
Good -	• Tolerates normal moderate resistive activity and position changes with minimal fatigue. • Standing tolerance is 20 minutes. • Patient can ambulate up to 300 feet.	1 – 19% Impairment: CI
Good	• Tolerates mod to max resistive activity and position changes without signs of fatigue. • Standing tolerance is 30 minutes or more. • Patient can ambulate 400 feet or more.	0% Impairment: CH

Static Balance Scale

Grade	Description	% Impairment
Poor	Max assist to maintain static position	100% Impairment: CN
Poor +	Mod assist to maintain static position	80 – 99% Impairment: CM
Fair -	Min assist to maintain static position	60 – 79% Impairment: CL
Fair	Stand-by assist or verbal cues for static position	40 – 59% Impairment: CK
Fair +	Independent for static position without resistance	20 – 39% Impairment: CJ
Good -	Maintains static position against min resistance	1 – 19% Impairment: CI
Good	Maintains static position against mod resistance	0% Impairment: CH

Dynamic Balance Scale

Grade	Description	% Impairment
Poor	Unable to move from midline voluntarily, requires max assist to right themselves	100% Impairment: CN
Poor +	Unable to move from midline voluntarily, requires mod to min assist to right themselves	80 – 99% Impairment: CM
Fair -	Able to perform dynamic activities with min assist	60 – 79% Impairment: CL
Fair	Able to perform dynamic activities with stand-by assist and verbal cues	40 – 59% Impairment: CK
Fair +	Able to perform dynamic activities with distant supervision or verbal cues	20 – 39% Impairment: CJ
Good -	Independent in basic dynamic balance activities	1 – 19% Impairment: CI
Good	Independent in functional dynamic balance activities	0% Impairment: CH

Seated Wheelchair Tolerance

Time	% Impairment
Unable to tolerate a seated position	100% Impairment: CN
Able to tolerate up to 1 hour seated	80 – 99% Impairment: CM
Able to tolerate up to 3 hours seated	60 – 79% Impairment: CL
Able to tolerate up to 5 hours seated with max physical assist to reposition self to avoid fatigue, dyspnea, and/or pain	40 – 59% Impairment: CK
Able to tolerate up to 6 hours seated with min physical assist to reposition self to avoid fatigue, dyspnea, and/or pain	20 – 39% Impairment: CJ
Able to tolerate up to 6 hours seated with cues to reposition self to avoid fatigue, dyspnea, and/or pain	1 – 19% Impairment: CI
Able to tolerate 6 hours or more seated, independently repositioning self when necessary to avoid fatigue, dyspnea, and/or pain	0% Impairment: CH

Splint/Orthotic Tolerance

Time	% Impairment
Unable to tolerate splint/orthotic	100% Impairment: CN
Able to tolerate up to 1 – 19% of wear schedule	80 – 99% Impairment: CM
Able to tolerate up to 20 – 39% of wear schedule	60 – 79% Impairment: CL
Able to tolerate up to 40 – 59% of wear schedule with max physical assist to don, doff, or reposition splint/orthotic to avoid skin breakdown or pain	40 – 59% Impairment: CK
Able to tolerate up to 60 – 79% of wear schedule with min physical assist to don, doff, or reposition splint/orthotic to avoid skin breakdown or pain	20 – 39% Impairment: CJ
Able to tolerate 80 – 99% of wear schedule with cues to don, doff, or reposition splint/orthotic to avoid skin breakdown or pain	1 – 19% Impairment: CI
Able to tolerate 100% of wear schedule, independently repositioning splint/orthotic when necessary to avoid skin breakdown and pain	0% Impairment: CH

Trunk Control

Time	% Impairment
Patient unable rotate trunk, sit unsupported for any time, **and** reach forward/laterally past midline.	100% Impairment: CN
Patient unable to rotate trunk, sit unsupported for any time, **and/or** reach forward/laterally past midline 1 – 3 inches.	80 – 99% Impairment: CM
Patient able to rotate trunk through partial range of motion bilaterally and/or only to one side, sit unsupported for 1 – 5 minutes, **and/or** reach forward/laterally past midline 3 – 5 inches	60 – 79% Impairment: CL
Patient able to rotate trunk through partial range of motion bilaterally and/or only to one side, sit unsupported 5 – 10 minutes, **and/or** reach forward/laterally past midline 5 – 7 inches.	40 – 59% Impairment: CK
Patient able to rotate trunk through a majority of range of motion bilaterally, sit unsupported for 10 – 20 minutes, **and/or** reach forward/laterally past midline 7 – 9 inches.	20 – 39% Impairment: CJ
Patient able to rotate trunk through a majority of range of motion or more bilaterally, sit unsupported 20 – 30 minutes, **and/or** reach forward/laterally past midline 9 – 11 inches.	1 – 19% Impairment: CI
Patient able to rotate trunk through full range of motion, sit unsupported for > 30 minutes, **and** reach forward/laterally past midline > 11 inches.	0% Impairment: CH

CPT / G-Codes

Functional Outcome Measure	Outcome Score Range	H	I	J	K	L	M	N	Comments
Five times Sit to stand	Inability to rise from a chair 5x in less than 13.6 seconds is associated with increased disability and morbidity. Optimal cutoff time for performing the FTSS in predicting recurrent fallers is 15 seconds. Norms for 60-69 yrs. = 11.4 seconds, 70-79 yrs. = 12.6 seconds, 80-89 yrs. = 14.8 seconds.	Less than or equal to 11 seconds.	11.1 - 12 seconds	12.1 - 13 seconds	13.1 - 14 seconds	14.1 - 15 seconds	15.1 - 16 seconds	Unable to complete test.	
30 Second chair rise	Normal range of scores, i.e., between 25% and 75% of the general population based on the number of stands in 30 seconds, also based on gender.	Female = 12 - 17 stands Male = 14 - 19 stands	F = 11-16 M = 12-18	F = 10-15 M = 12-17	F = 10-15 M = 11-17	F = 9-14 M = 10-15	F = 8-13 M = 8-14	F = 4-11 M = 7-12	This is actually based on age but works nicely for impairment.
Barthel Index of ADLs	0-100	0 - 6	7 - 23	24 - 40	41 - 58	59 - 76	76 - 92	93 - 100	
Berg balance scale	0 - 56 (Full Scale) 41-56 = Low fall risk 21-40 = Medium fall risk 0 –20 = High fall risk	51 - 56	46 - 50	36 - 45	26 - 35	16 - 25	6 - 15	0 - 5	
Borg Rating of perceived exertion	Scale is 9 - 19. 6 or < Normal	0 - 8	9 - 10	11 - 12	13	14 - 15	16 - 17	18 - 19	
Brief cognitive assessment tool (BCAT)	0 - 50	50	40 - 49	30 - 39	20 - 29	10 - 19	1 - 9	0	
Brief cognitive assessment scale (Severe Dementia)	0 - 7	1	2	3	4	5	6	7	
Brunel Balance Assessment	0 - 12	11 - 12	9 - 10	7 - 8	5 - 6	3 - 4	1 - 2	0	
Dynamic gait index	Max Score = 24 < 21 = Risk	20 - 24	18 - 19	16 - 17	14 - 15	12 - 13	10 - 11	9 or <	

CPT / G-Codes

Elderly mobility scale	0 - 20 Full scale 20 = Independent 0 = Total Assist	17 - 20	15 - 16	13 - 14	11 - 12	9 - 10	6 - 8	0 - 5	
Fullerton Advanced balance scale (FAB)	0 - 40	35 - 40	25 - 34	20 - 24	15 - 19	10 - 14	1 - 5	0	Cut Off 25/40
Functional gait assessment	0 - 30	30	24 -29	18 -23	12-17	6-11	1-5	0	
Functional reach test	0" - 11"	> 11"	9" - 11"	7" - <9"	5" - <7"	3" - <5"	>1" - <3"	0" - 1"	
Gate abnormality rating scale modified (GARS – M)	0 - 21	21	17 - 20	13 - 16	10 - 13	6-9	2-5	0-1	
Katz Index of ADL	*****								Not measurable
Kettle test	0 - 52	0 - 5	5 - 15	16 - 25	26 - 34	35 - 43	43 - 47	48 - 52	
Kitchen picture (BCAT)	0 - 21	21	17 - 20	13 - 16	9 - 12	5 - 8	1 - 4	0	
Late Life Function Instrument									
Musculoskeletal conditions MAM–20	0 to 100 MAM Score	100	81 - 99	'61 - 80	41 - 60	'21 - 40	1 - 20	0	
Neurologic conditions MAM–20	80 = No Impairment; 20 = 100% Impairment	80	74 - 79	59 - 73	44 - 58	31 - 43	21 - 30	20	
St. Louis University mental status exam (SLUMS)	**With HS Diploma:** 27-30 = Normal 21-26 = Mild Neuro Cog Disorder 1-20 = Dementia **W/Out HS Diploma:** 25-30 = Normal 20-24 = Mild Neuro Cog Disorder	27 - 30	24 - 26	20 - 23	15 - 19	8 - 14	3 - 7	1 - 3	
Timed up and go	1 19 D I *****								Not measurable
Tinetti balance and gait assessment	0 - 28 scale	25 - 28	23 - 25	19 - 22	15 - 18	11 - 14	6 - 10	1 - 5	

CPT / G-Codes

Functional Communication Measure	1 - 7	1	2	3	4	5	6	7	Attention, Memory, Motor Speech, Reading, Spoken Language Comprehension, Spoken Language Expression, Swallowing, Writing

CMS Part B Billing Scenarios

This page is designed to clarify existing therapy policy and to provide guidance on current Part B billing issues relevant to physical therapists (PTs), occupational therapists (OTs) and speech-language pathologists (SLPs) and to the services they provide. Because we have received numerous requests to restore the previously published 11 Frequently Asked Questions (FAQs) resulting from the 9/13/02 Open Door Forum on Group Therapy, we have chosen to reformat these FAQs into "billing scenarios" to appear below. As a result, the 11 Part B Billing Scenarios are specific to PTs and OTs. We will update this Web Page to reflect changes in policy (for example, CCI edits, new codes, new coverage determinations) that impact therapy billing and/or to provide clarification on billing policy for PTs, OTs and/or SLPs.

Check the manuals first

Therapy Manual References

- Medicare Claims Processing Manual, 100-4, Chapter 5, Sections 10, 20, 30, 40, 100
- Medicare Benefit Policy Manual, 100-2, Chapter 15, sections 220 and 230

The Medicare contractor who pays your claims is the best source of answers to specific Medicare questions. Contractors are carriers, intermediaries or Program Safeguard Contractors who interpret Medicare laws, develop local policies and educate providers. Contractor websites list local policies. You may also contact your Medicare Regional Office for assistance.

11 Part B Billing Scenarios for PTs and OTs

The following billing scenarios formerly appeared on the Frequently Asked Questions (FAQ) website and on the Therapy Medlearn website as "11 FAQs" - posted 9/13/02 Open Door on Group Therapy.

CMS Assumptions

The following CMS assumptions were used in constructing the following billing scenarios regarding Part B therapy services. These represent requirements that are necessary pre-conditions to the information that follows and are part of the service delivery framework that CMS assumes is in place when Part B therapy services are delivered:

- Physical and Occupational Therapists (PTs and OTs) and their therapy assistants - physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) meet Medicare personnel qualifications.
- All therapy provided consists of skilled and medically necessary services and is appropriate to each patient's plan of care.
- Therapists can enroll in Medicare as providers of PT or OT services, but therapy assistants cannot. T he services of the therapy assistant are billed through the enrolled therapist, or other therapy provider.

- The therapist reports the time the therapy assistant provides care, whether it is one-on-one care or delivered via the untimed codes, such as supervised modalities or group therapy.

- All Medicare rules are met with respect to supervision requirements for therapy assistants in their respective settings. For example: (1) direct ("in the office suite") supervision in private practice PT or OT therapy settings and (2) general supervision in the following settings: OPPS, SNF, CORF, Rehab Agency and the HHA.
- Each therapist's supervision of therapy assistant(s) is in compliance with all State laws and regulations and with local medical review policies.

References

The following references are used throughout the billing scenarios that follow:

1. Definitions of qualified therapy personnel: 42 C.F.R. 485.705, 484.4
2. Reasonable and necessary: Program Integrity Manual Chapter 13, Section 5.1
3. Skilled therapy: Benefits Policy Manual, 100-02, Chapter 15, Sections 220 and 230
4. CPT Definitions: CPT 2004, American Medical Association Press
5. Counting of timed codes: Claims Processing Manual, 100-04, Chapter 5, Section 20.3, and Program Memorandum AB-01-68 (May 1, 2001)
6. SNF Therapy: Federal Register, 66 Fed. Reg. 39567 (July 31, 2002)
7. Correct Coding Initiative websites:
    - Physician Fee Schedule
    - Hospital Outpatient PPS
8. User's Manual for the Minimum Data Set (MDS) Version 2.0, Revised December 2002, Revised Long Term Care Resident Assessment Instrument:

1. Billing - CPT Codes: Not Permitted

In the same 15-minute (or other) time period, a therapist cannot bill any of the following pairs of CPT codes for outpatient therapy services provided to the same, or to different patients. Examples include:

a. Any two CPT codes for "therapeutic procedures" requiring direct one-on-one patient contact (CPT codes 97110-97542);
b. Any two CPT codes for modalities requiring "constant attendance" and direct one-on-one patient contact (CPT codes 97032 - 97039);
c. Any two CPT codes requiring either constant attendance or direct one-on-one patient contact - as described in (a) and (b) above -- (CPT codes 97032- 97542). For example: any CPT code for a therapeutic procedure (eg. 97116-gait training) with any attended modality CPT code (eg. 97035-ultrasound);
d. Any CPT code for therapeutic procedures requiring direct one-on-one patient contact (CPT codes 97110 - 97542) with the group therapy CPT code (97150) requiring constant attendance. For example: group therapy (97150) with neuromuscular reeducation (97112);
e. Any CPT code for modalities requiring constant attendance (CPT codes 97032 - 97039) with the group therapy CPT code (97150). For example: group therapy (97150) with ultrasound (97035);
f. Any untimed evaluation or reevaluation code (CPT codes 97001-97004) with any other timed or untimed CPT codes, including constant attendance modalities (CPT codes 97032 - 97039), therapeutic procedures (CPT codes 97110-97542) and group therapy (CPT code 97150)

See reference numbers 4. and 5. above.

2. Billing - CPT Codes: Permitted

In the same 15-minute time period, one therapist may bill for more than one therapy service occurring in the same 15-minute time period where "supervised modalities" are defined by CPT as untimed and unattended -- not requiring the presence of the therapist (CPT codes 97010 - 97028). One or more supervised modalities may be billed in the same 15-minute time period with any other CPT code, timed or untimed, requiring constant attendance or direct one-on-one patient contact. However, any actual time the therapist uses to attend one-on-one to a patient receiving a supervised modality cannot be counted for any other service provided by the therapist.

See reference numbers 4. and 5. above.

3. Group Therapy-vs- Individual Therapy:

The following is provided to assist you in determining whether to bill for group therapy (97150) or individual therapy (defined by the timed CPT codes for therapeutic procedures requiring direct one-on-one patient contact), when treating two patients during the same time period.

When direct one-on-one patient contact is provided, the therapist bills for individual therapy, and counts the total minutes of service to each patient in order to determine how many units of service to bill each patient for the timed codes. These direct one-on-one minutes may occur continuously (15 minutes straight), or in notable episodes (for example, 10 minutes now, 5 minutes later). Each direct one-on-one episode, however, should be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's plan of care. Also, the manner of practice should clearly distinguish it from care provided simultaneously to two or more patients.

Group therapy consists of simultaneous treatment to two or more patients who may or may not be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of group therapy, 97150 (untimed).

a. **One-on-One Example:** In a 45-minute period, a therapist works with 3 patients - A, B, and C - providing therapeutic exercises to each patient with direct one-on-one contact in the following sequence: Patient A receives 8 minutes, patient B receives 8 minutes and patient C receives 8 minutes. After this initial 24-minute period, the therapist returns to work with patient A for 10 more minutes (18 minutes total), then patient B for 5 more minutes (13 minutes total), and finally patient C for 6 additional minutes (14 minutes total). During the times the patients are not receiving direct one-on-one contact with the therapist, they are each exercising independently. The therapist appropriately bills each patient one 15 minute unit of therapeutic exercise (97110) corresponding to the time of the skilled intervention with each patient.
b. **Group Example:** In a 25-minute period, a therapist works with two patients, A and B, and divides his/her time between two patients. The therapist moves back and forth between the two patients, spending a minute or two at a time, and provides occasional assistance and modifications to patient A's exercise program and offers verbal cues for patient B's gait training and balance activities in the parallel bars. The therapist does not track continuous or notable, identifiable episodes of direct one-on-one contact with either patient and would bill each patient one unit of group therapy (97150) corresponding to the time of the skilled intervention with each patient.

See reference numbers 4. and 5. above.

4. Team Therapy:

Therapists, or therapy assistants, working together as a "team" to treat one or more patients **cannot** each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both. Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

See reference numbers 4. and 5. above.

5. Counting Minutes of Service Units

Billing of six units over a 60-minute period by providing direct one-on-one treatments to six patients for 10 minutes each:

If more than one timed CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. Medicare's expectation (based on the work values for these CPT codes) is that a therapist's direct one-on-one patient contact time will average 15 minutes in length, for each unit. Therapy sessions of should not be structured to consistently provide less than an average of 15 minutes treatment for each timed unit. Routine billing of the above-described practice (10-minute treatment sessions) results in an average workload that exceeds the expected time frames and would likely cause the contractor to question whether the services were reasonable and necessary.

In the case of group therapy, an untimed code, Medicare expects that skilled, medically necessary services will be provided as appropriate to each patient's plan of care. Therefore, group therapy sessions should be of sufficient length to address the needs of each of the patients in the group.

See reference number 5. above.

6. Group and Individual CPT Codes Billed on Same Day:

Billing for both individual (one-on-one) and group services provided to the same patient in the same day:

This is allowed, provided the CPT and CMS rules for one-on-one and group therapy are both met. However, the group therapy session must be clearly distinct or independent from other services and billed using a -59 modifier.

The group therapy CPT code (97150) and the direct one-on-one 15-minute CPT Codes for therapeutic procedures (97110 - 97542) are subject to Medicare's Correct Coding Initiative (CCI). The CCI edits require the group therapy and the one-on-one therapy to occur in different sessions, timeframes, or separate encounters

that are distinct or independent from each other when billed on the same day. The therapist would use the -59 modifier to bill for both group therapy and individual therapy CPT codes to distinguish that the two coded services represent different sessions or separate encounters on the same day. Without the -59 modifier, payment would be made for the lower-priced group therapy CPT Code, in accordance with CPT/CCI rules. The CCI edits are based upon interpretation of coding rules.

The National Correct Coding Initiative website contains a section titled "How To Obtain Assistance With Questions Related to CCI Edits" that may be helpful. In addition to the group therapy edits, CCI edits are applied to certain other pairs of CPT codes used by physical and occupational therapists. The CCI website contains a link to the National Technical Information Service (NTIS) website for information on obtaining the CCI Edits Manual and now lists current CCI edits.

See reference number 7. above.

7. Supervision:

The services of a therapist or therapy assistant **cannot** be billed for supervising a patient who is independently performing a therapeutic exercise program.

Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists or appropriately supervised therapy assistants. Supervising patients who are exercising independently is not a skilled service.

See reference numbers 1. and 3. above.

8. Qualified Personnel:

You **cannot** bill Medicare for the services of an aide that is supervised by the therapist or therapy assistant.

Medicare Part B does not pay for the services provided by aides regardless of the level of supervision. Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists and appropriately supervised therapy assistants.

See reference numbers 1. and 3. above.

9. Group Frequency:

In private practice settings for physical and occupational therapists and in physician offices where therapy services are provided incident to the physician, Medicare expects the group therapy code (97150) to be billed only once each day per patient. In the facility/institutional therapy settings, the group therapy code could be applied more than once. However, the occasional situation where group therapy is billed more than once each day would require sufficient documentation to support its medical necessity and clinical appropriateness of

providing more than one separate session of group therapy.

See reference number 4 above.

10. Documentation:

Records need to be maintained in order to demonstrate that billing for individual therapy or group therapy was proper:

CMS provides guidance on the reporting of service units that includes documentation instructions. A therapist or therapy assistant should record the total treatment time (or the actual beginning and ending time of treatment) for services described by timed codes, untimed codes and unattended (billed and unbilled) activities. **The total number of timed 15-minute units that can be billed by the therapist (whether performed by the therapist or therapy assistant) for each patient is constrained by the total time of the skilled therapeutic one-on-one intervention by the therapist or therapy assistant.** For the untimed codes, including "supervised" modalities, group therapy, and the evaluation codes, documenting the session time can help to justify the appropriateness of the services provided.

Alternatively, in cases where recording the total treatment time may not be sufficient to describe the extent of the therapeutic procedures or where certain practice policies require it, the time spent delivering each service described by either a timed or untimed CPT code could be recorded. In these cases, the therapist could document (a) the total time or the beginning and ending time for each session defined by a timed code and/or (b) the total time (or segments of time) in which the patient is involved in services defined by untimed codes and unattended codes.

See reference number 5. above.

11. SNF Part B Billing:

In a SNF, when a therapist is working simultaneously with two or more residents - at least one each from Part A and Part B - providing the same or different activities, the regulations for each payer source must be followed. Examples of possible billing scenarios follow:

- A therapist treats one Part A resident and one Part B resident during the same 30-minute session, providing different activities to each, and does not track identifiable one-on-one episodes of direct care with either patient. The therapist would bill one unit of 97150 (group) for the Part B resident, and code the total time, 30 minutes, toward the MDS as individual treatment time for the Part A resident.
- A therapist treats one Part A resident and one Part B resident during the same 30-minute session, providing the same or similar activities to each, and not tracking identifiable one-on-one episodes of care with either patient. The therapist would bill one unit of 97150 (group) for the Part B resident and code the total time, 30 minutes, toward the MDS as group treatment time for the Part A resident.

Note: Part A therapy is different from Part B:

- In order to be considered group therapy under Part A, the SNF residents perform similar activities whereas, under Part B, the therapeutic interventions can be similar or different; and,
- SNF therapy services are paid as part of the bundled PPS rate and not reimbursed under the physician fee schedule as they are under Part B.

See reference numbers 6. and 8. above.

Source: www.CMS.gov

Documentation Policy and Procedure

Requirements

Policy

Therapy documentation will be technically complete, timely and accurate, will comply with corporate and facility standards, and will meet state and federal regulations.

Scope

Documentation requirements will be the same for all residents receiving a therapy program regardless of financial classification.

Overview

The appropriate therapy personnel will complete the required documentation.

Required documentation:

1. Rehabilitation Screen
2. Physician's Orders/Telephone Order Request
3. Evaluation/Certification
4. Recertification/Monthly Summary
5. Resident Care Plan
6. Daily Treatment Record
7. Weekly Progress Report
8. Discharge Summary
9. Discharge Order

Documentation Policy and Procedure

Rehabilitation Screen

Policy

A Rehabilitation Screening from will be completed by a licensed P.T., O.T., and S.L.P. staff whenever a resident is admitted to the facility, annually, and for current residents on an ongoing basis.

Scope

Completed rehabilitation screening forms will be maintained in the resident's medical record. The resident data sheet will be kept in a discipline specific alphabetized book in the rehabilitation department.

Purpose

The screening form will indicate the need for further assessment.

Procedure

1. Upon admission, all residents will be screened if physician orders for evaluation are not present on admission. Every resident will be screened at least annually by each rehabilitation service available in the facility.

2. Rehab screens will be completed upon referral from the facility's clinical team.

3. The resident data sheet will be completed, followed by the screening form, and the screening log.

4. The resident data sheet will be placed in the alphabetical index, the log will remain in the log tab, and the screening form in the monthly index behind the month of the next scheduled screen.

5. The screening schedule will be initiated by each rehab service screening those residents listed on the care planning list and all admissions/readmissions.

6. All rehab services will be available and offer input to the care planning team for those residents screened.

7. The outcome of a rehab screen will be no evaluation is indicated, an evaluation is indicated or referral for a screen by another discipline. Rehab screens will not generate recommendations that will impact the plan of care or require a formal evaluation.

8. A rehab screen will result in a formal evaluation request if recommendations are required to ensure all recommendations are effective and implemented.

Documentation Policy and Procedure

Physician Order

Policy

All therapy orders and/or changes in orders must appear in the Physician Order (P.O.) section of the medical record. Therapy orders received verbally from the physician must be written on a Telephone Order (T.O.) by a nurse per facility policy and signed by the physician.

Scope

All residents, regardless of financial classification, must have a P.O., for therapy treatment prior to therapy being initiated, when the therapy program changes, and when therapy is discontinued.

Procedure

1. Obtain the initial P.O. by one of the following mechanisms:
    a. The resident is admitted to the facility with therapy orders.
    b. The physician enters the therapy orders in the chart during a facility visit.
    c. The licensed therapist or nurse contacts the physician and requests a T.O. for therapy to evaluate and treat as indicated.
2. When the evaluation is complete:
    a. The licensed therapist or nurse requests a clarification order from the physician for the therapy program to be provided. (ex., Physical Therapy for therapeutic exercises BLE's, transfer training and gait training qd 5x/wk x 6 wks.)
    b. Complete a T.O. form for the classification order.
3. To complete the Telephone Order form:
    a. The nurse will transcribe the order from the therapy communication form.
    b. Write the date, time, and order on the T.O. Include the discipline, specific treatment, duration, frequency and diagnosis if needed. (ex., Physical Therapy for therapeutic exercises BLE's, transfer training and gait training qd 5x/wk x 6 wks.)
    c. Sign the T.O. in medical records box to be mailed to physician for his signature.
4. Obtain a new therapy clarification order and follow procedures for completing a T.O. for the following:
    a. All residents who transfer from a Part A status to Part B status.
    b. Change in the therapy treatment program.
    c. Change in the frequency and duration.
5. Obtain a discharge order and follow procedures for completing a T.O. when the therapy is discontinued.

Documentation Policy and Procedure

Evaluation

Policy

An evaluation will be completed prior to the initiation of a therapy program when there is a P.O. for therapy intervention. An evaluation will be completed prior to making any recommendations impacting the care plan for the resident.

Scope

The licensed therapist will perform and document the evaluation.

Procedure

1. The evaluation is to be initiated within 48 hours of the P.O.
2. If the evaluation cannot be completed on the day initiated, document this information on the discipline specific treatment grid form (ex., Evaluation initiated on 11/2/01 and is currently in progress.)
3. Place a copy of the evaluation form in the medical record when it is completed. Send the original to the physician for signature.
4. Original evaluations should be signed by physician within 10 work days and placed in the medical record when it is completed/signed.
5. Maintain a copy of the evaluation in a soft file in the rehabilitation department.

Documentation Policy and Procedure

Plan of Treatment/Monthly Summary

Policy

A therapy Plan of Treatment will be completed prior to initiation of a therapy program and every 30 days in which the therapy program continues.

Scope

The licensed therapist will establish the Plan of Treatment and will complete the Plan of Treatment/Monthly Summary form on a timely basis for all residents on a therapy program.

Procedure

1. Initiate the Plan of Treatment/Month Summary when the evaluation is completed if a therapy program is indicated.

2. Plan of treatment updates are required every 30 days. Do not exceed 30 days.

3. If therapy treatment is to continue in the next month, initiate an updated Plan of Treatment/Month Summary at the beginning of the new month. Complete this plan of treatment at the end of the month or when the therapy program is terminated during the month.

4. In the month that Part A coverage is terminated, complete the Plan of Treatment/Monthly Summary through the last day of Part A treatment.

5. To continue a therapy program from Part A to Part B or to begin a therapy program on Part B, it is necessary to do the following at the time Part B is initiated:

    a. Obtain a telephone order to continue with the therapy program, make any changes to the program, or to begin a therapy program.

    b. Initiate a new Plan of Treatment/Monthly Summary.

    c. Place a copy of the new Plan of Treatment/Monthly Summary in the medical record.

    d. Send the original form to the physician. The physician is to sign and date the form within 30 days of the last signature and return it to the facility.

    e. When the form is received from the physician, remove the copy from the medical record and replace with the signed and dated original form.

6. If therapy is to continue in the next month, initiate a new Plan of Treatment/Monthly Summary form at the beginning of the new month and follow steps 5c, 5d, and 5e.

7. Maintain the Plan of Treatment/Monthly Summary for each month of service in the medical record.

   Note: When transferring a resident from Part A to Part B you will need to discharge the resident from Part A and complete your discharge paperwork.

Documentation Policy and Procedure

Resident Care Plan

Policy

The Resident Care Plan will include the intervention for every Rehab resident after the therapy evaluation is completed and a treatment plan is determined The Care Plan will be updated as needed, but at least quarterly.

Scope

The therapist who establishes the therapy plan of treatment will enter in the care plan according to facility protocol.

Procedure

1. Document the date that entry is made. If the Care Plan is being rewritten each problem retains its original entry date. If a specific problem is reassessed, write in the new date, new goal, and new approaches as possible.

2. Needs/Problems - Enter clear, concise statement of the problem/need in measurable functional terminology.

3. Short Term Goal/Objective - Enter the goal/objective - end result, desired state, final outcome. Goal should be Resident-Centered. It is the resident's goal. Enter the time frame in which the goal is to be accomplished.

4. Approach - Enter the specific steps to be taken to reach the goal/objective. Include the action to be performed and the frequency and duration.

5. Discipline Involved - Utilize the code at the top of the form to indicate the discipline responsible for implementation of each approach. Problems that have more than one discipline involved should reflect each discipline.

6. Date Resolved/Assessment - Enter the goal date of reassessment. If the problem is a permanent or ongoing one, the month and year can be used to indicate when quarterly review will occur. Goal time limits for temporary or episodic problems should be specific as to month, day and year so it is clear exactly when the goal and the approaches will be reviewed. When a problem is "resolved". Highlighter may be used to help staff recognize a resolution.

7. The long-term goal will be entered in the designated space at the bottom of the form. Long term goals state the intended results of the overall Plan of Care over an extended period of time.

Documentation Policy and Procedure

Treatment Grid Daily Documentation

Policy

The treatment grid daily documentation will be completed timely and accurately by the appropriate therapy personnel.

Scope

A treatment grid will be completed daily for each resident receiving therapy for the current month of service.

Procedure

1. Document in the progress note section the date the evaluation was completed. (ex., 11/2/01 Evaluation completed.)
2. Document in the progress note section the date the plan of treatment was discussed with the resident and/or responsible party. (ex., 11/2/01 the plan of treatment was discussed with the resident.)
3. Document on the treatment grid the treatment provided on that day of service by each therapist providing any portion of the treatment.
4. All progress note entries are to be signed by the appropriate therapist.
5. Maintain the form in the medical record.

Documentation Policy and Procedure

Progress Notes

Policy

All Rehab patients will have a Progress Note completed by a Therapist weekly.

Procedure

1. Update the resident's Care Plan when the therapy treatment program or resident's status changes. (Highlight entry and date when resolved).
2. Complete the functional level section of form. Include progress made and goals achieved.
3. Address the specific functional progress and or progress within levels of care for each established goal. Update new short-term goals as needed.
4. Document justification for continued skilled therapy intervention (medical complexity, potential to achieve goals, deficits, etc.).
5. Address patient/care giver education completed.
6. Place the progress note in the medical record.

Documentation Policy and Procedure

Discharge Summaries

Policy

All residents being discharged from therapy shall have a Discharge Summary written. A discharge order will be obtained when a resident is being discharged from a therapy program.

Procedure

1. Consult with the referring physician to obtain a discharge order when a resident is being discharged. Follow documentation procedure for completing a telephone order.

2. The therapy must be discharged from the resident's Care Plan when the therapy treatment program is discontinued. (Highlight entry and date when resolved). Ensure recommendations that will continue after the discontinuation of therapy are updated.

3. Complete the functional level section of form. This can serve as the discharge summary and is to include progress made, goals achieved, reason for discharge and follow-up recommendations to maintain present functional level.

4. Submit a completed copy of the Plan of Treatment/Monthly Summary to the facility bookkeeper at the end of the month.

5. Place the discharge summary information in the medical record.

6. A copy of the discharge summary can be mailed to the attending physician.

Documentation Policy and Procedure

Home Treatment Program

Policy

All residents returning home or to a lesser level of care, upon discharge from an active Rehab program should be given home instruction. This home program should consist of specific exercises, ADL recommendations, energy conservation techniques, and/or other pertinent resident specific information.

Procedure

1. Home instruction should be incorporated early in the treatment program.
2. Training should be provided to both resident and primary caretaker (family/attendant) with satisfactory return demonstration obtained.
3. Written instruction should be reviewed with resident and primary caretaker. Complete the Home Program form and place one copy in the chart and give one copy top the resident.
4. Documentation should include the type of instruction given and who was instructed. (ex., Resident and family member(s) were provided with verbal and written instructions regarding total hip precautions).
5. Home instruction should be incorporated into the home discharge paperwork completed by the interdisciplinary team.

Documentation Policy and Procedure

Therapy Communication to Nursing

Policy

Nursing will be provided with written recommendations and approaches for follow up care in the facility when a resident is discontinued from an active rehab program.

Procedure

1. Provide instruction to nursing staff before the therapy program is discontinued.
2. Allow adequate time for the nursing personnel to learn the program to be followed. Return demonstration should be satisfactory for safety and properly managing the resident.
3. Complete the therapy to nursing communication form.
4. Review the written recommendation with the appropriate nursing personnel.
5. Provide a copy to the written recommendation to the resident's charge nurse and a place a copy in the medical record, or a log book designated by the interdisciplinary team.

Documentation Policy and Procedure

Part B Fee Schedule

Part B of the Medicare Program is medical insurance. This coverage helps pay for medical and surgical services by physicians, as well as certain other health benefits such as ambulance transportation, durable medical equipment, outpatient hospital services, and independent laboratory services. It is designed to complement the coverage provided by Part A of the Program. Fee Schedules for Medicare Part B are updated every January.

Policy: The Rehabilitation Manager will obtain the current Medicare Part B Fee schedules for each Medicare Part B each billable CPT Code in January of each calendar year.

1. Contact the Business Office Manager for updated CPT Part B Fee schedules.
2. If the Business Office does not have a current listing of Medicare Part B Fee Schedules, review the attached "How to Use the Searchable Medicare Physician Fee Schedule (MPFS)" details the process for obtaining therapy fee schedules for each CPT code if not available from the facility Business Office.
3. The Searchable Medicare Physician Fee Schedule (MPFS) tool can be found at:

   http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

4. Select the year of the Medicare Physician Fee Schedule
5. Select Type of Information Pricing Information
6. Select one of the three options "Single HCPCS Code" or a "List of HCPCS Codes"
7. Select "Specific Locality"
8. If you selected Single HCPCS Code Enter the HCPCS code that you want to search the information for.
9. Enter your Specific Locality from the drop-down Menu.
10. Click on Submit.
11. Your facility specific Part B rate is listed under Facility Price. The fee schedule can be downloaded, printed, or emailed.

Documentation Policy and Procedure

How to Use the Searchable Medicare Physician Fee Schedule (MPFS)

http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

To Learn More…

If you find this How To booklet helpful, then you may wish to review the other booklets in this series. To locate these booklets, go to the MLN Publications page at http://go.cms.gov/MLNProducts and search for items containing the words "how to."

Introduction

What is the Searchable Medicare Physician Fee Schedule (MPFS)?

The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Search Tool provides Medicare payment information on more than 10,000 services, including pricing, the associated Relative Value Units (RVUs), and various payment policies.

CPT Disclaimer-American Medical Association (AMA) Notice

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

ICN 901344 April 2016

Why Would a Health Care Professional, Supplier, or Provider Use the Searchable MPFS?

The MPFS is the primary method of payment for enrolled health care professionals. Specifically, Medicare uses this fee schedule when paying the following services:

- Professional services of physicians and other enrolled health care professionals in private practice;
- Services covered incident to physicians' services (other than certain drugs covered as incident to services);
- Diagnostic tests (other than clinical laboratory tests); and
- Radiology services.

In addition, suppliers such as Mammography Centers are paid according to the MPFS. Institutional providers such as hospitals, Comprehensive Outpatient Rehabilitation Facilities (CORFs), and Skilled Nursing Facilities (SNFs) are paid for some services under the MPFS depending on the institution type and service. For example, hospital outpatient departments are paid for screening mammographies and outpatient rehabilitation services under the MPFS.

The searchable MPFS allows health care professionals, suppliers, and institutional providers to find the Medicare payment amount for each code so they may calculate the beneficiary coinsurance amount. In addition, for those health care professionals/suppliers who choose to be nonparticipating, the MPFS provides the limiting charge.

Participating Health Care Professionals and Suppliers have enrolled in Medicare and have signed the Form CMS-460, "Medicare Participating Physician or Supplier Agreement," agreeing to charge no more than Medicare-approved amounts and deductibles and coinsurance amounts. Participating professionals and suppliers submit assigned claims.

Assigned Claims are submitted by the health professional/supplier/provider on behalf of the beneficiary. Medicare issues payment to the submitter.

Nonparticipating Health Care Professionals and Suppliers enroll in Medicare but have decided not to sign the Form CMS-460. They accept assignment on a case-by-case basis. For services paid under the MPFS, there is a 5 percent reduction in the Medicare-approved amounts for nonparticipants. Also, there is a limit on what the health care professional/supplier may charge the beneficiary (LIMITING CHARGE) when they choose not to accept assignment on the claim.

Limiting Charge equals 115 percent of the nonparticipating fee schedule amount and is the maximum the nonparticipant may charge a beneficiary on an unassigned claim. The

nonparticipating fee schedule amount is equal to 95 percent of the Medicare Physician Fee Schedule.

Unassigned Claims are submitted by a nonparticipating health care professional or supplier who is not accepting assignment on the claim. Medicare issues payment to the beneficiary.

Print out the "Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide" in this booklet for a step-by-step summary of how to use the MPFS Search Tool.

The searchable MPFS is also an excellent way to learn if Healthcare Common Procedure Coding System (HCPCS) codes are affected by payment policies such as payment of assistant at surgery services, applicability of certain modifiers, and physician supervision of diagnostic services.

Helpful Hint

Additional information about these and other payment policies are found in the CMS Internet-Only Manuals (IOMs). In addition, search the National Correct Coding Initiative (NCCI) at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html to identify NCCI code pair edits and Medically Unlikely Edits (MUEs). Search the Medicare Coverage Database (MCD) at http://www.cms.gov/medicare-coverage-database to review national and local coverage determinations. The Medicare Learning Network® has created the "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools" and "How to Use the Medicare Coverage Database" booklets to assist you.

Background

A fee schedule is a complete listing of fee maximums used by Medicare to pay physicians, other enrolled health care professionals, or providers/suppliers on a Fee-For-Service (FFS) basis. Medicare bases payment on whichever is less, the charge or MPFS amount. In addition to the MPFS, CMS develops fee schedules for ambulance services, clinical laboratory services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

For most codes, Medicare pays 80 percent of the amount listed and the beneficiary is responsible for 20 percent.

Examples of reductions from the published MPFS amount include:

- Assistants at surgery receive 16 percent of the MPFS rate;
- Nurse practitioners, physician assistants, and clinical nurse specialists are paid 85 percent;
- Registered dietitians or nutrition professionals, for medical nutrition therapy services,

are paid 85 percent; and
- Clinical social workers receive 75 percent.

Helpful Hint

Refer to IOM Publication (Pub.) 100-04, "Medicare Claims Processing Manual," Chapter 12, "Physicians/ Nonphysician Practitioners," at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf for more information.

How Up-to-Date is the Searchable Medicare Physician Fee Schedule?

The searchable MPFS is updated quarterly. The PFS Update Status on the MPFS Overview page shows the date of the latest update.

How to Locate the Searchable Medicare Physician Fee Schedule

The searchable MPFS is located at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx on the CMS website.

Searching The MPFS

The searchable MPFS is designed to take the user through the selection steps prior to the display of the information so the user may customize searches of:

- Pricing amounts;
- Various payment policy indicators;
- Relative Value Units (RVUs); and
- Geographic Practice Cost Indices (GPCIs).

To begin a search from the MPFS Overview page, either click on 'Physician Fee Schedule Search' in the navigation bar at the top of the page or scroll down and select 'Start Search.' To continue, click 'Accept' to indicate you have read and agree to the License for Use of Current Procedural Terminology, Fourth Edition ("CPT®").

The MPFS Search Criteria screen will appear. A portion of this screen is shown in Figure 1.

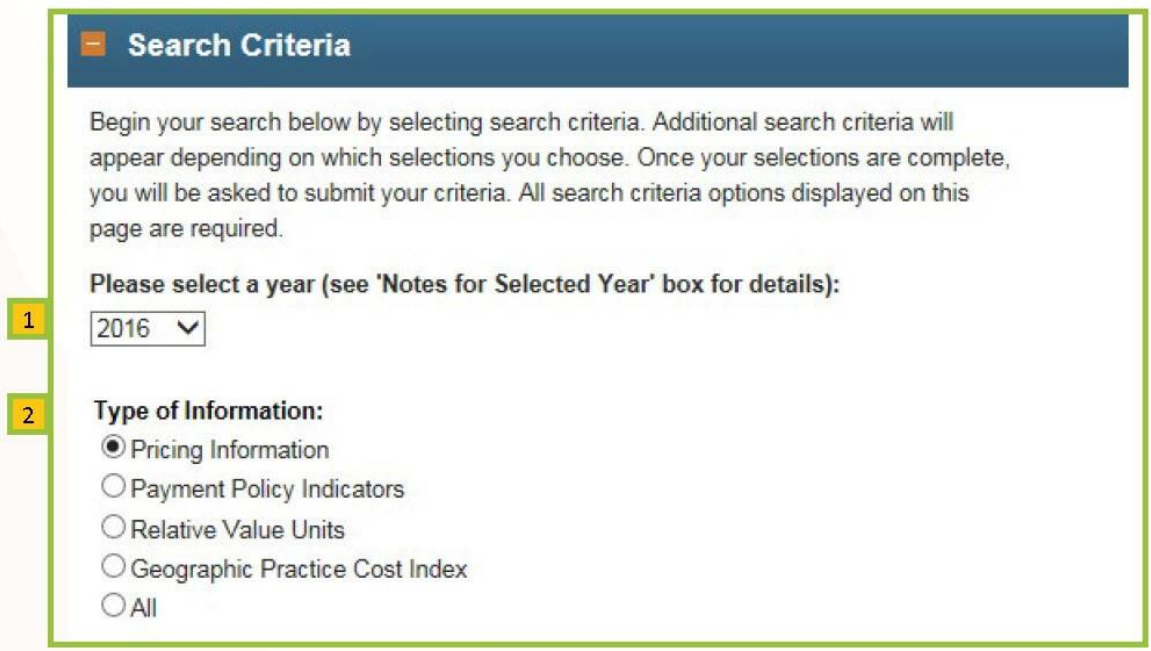


Figure 1: Search Criteria

To begin your search, select the following criteria:

1. Choose the year from the dropdown menu.

2. Then, select the Type of Information for the search from the following choices:

- **Pricing Information** - This search provides the maximum fee schedule amount by HCPCS code.
- **Payment Policy Indicators** - This option provides only payment policy indicators information such as global surgery days, multiple surgery indicators, and applicability of professional and technical components.
- **Relative Value Units (RVUs)** - For those interested in how the payment amount was calculated, this option provides RVU information for work, practice expense, and malpractice costs.
- **Geographic Practice Cost Index (GPCI)** - A GPCI has been established for every Medicare payment locality for each of the three components of a procedure's RVU.
- **All** - This option provides data for each of the above types of information.

Helpful Hint

If you are only interested in one of the above choices, there is a minor downside to choosing 'All' and that is, if you choose to print the results, you'll print more than what you need and will need to spend a little more time arranging the printing. Also, if you select one of the choices and then change your mind, you can easily switch from viewing only the default columns to all columns once your search results appear.

The remaining criteria options that are displayed vary based on the Type of Information selected for the search.

We will display the next steps of this search performing a Pricing Information Search and subsequently review the other choices of searches.

Pricing Information Search

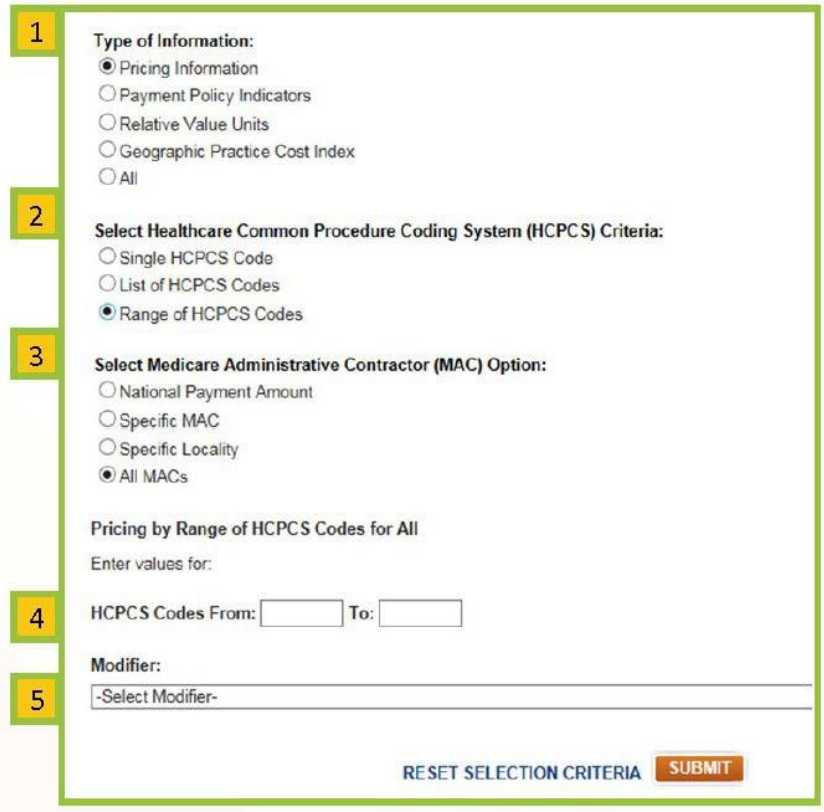


Figure 2: Pricing Information Search

1. Select **Pricing Information** for the Type of Information.

2. Select one of the following **Healthcare Common Procedure Coding System (HCPCS) Criteria** choices:

   - **Single HCPCS Code**
     - Enter one procedure code.
   - **List of HCPCS Codes**
     - Enter up to five codes.
   - **Range of HCPCS Codes**
     - Enter a starting and ending procedure code to define the range.

Helpful Hint

The MPFS includes Level I Current Procedural Terminology (CPT) and Level II HCPCS codes.

3. Select one of the following choices for the Medicare Administrative Contractor (MAC) criteria:

- National Payment Amount
  - This option searches for information for only the national payment amount. The national payment amount is designated with a MAC locality code of '0000000.'

- Specific MAC
  - This option searches for information by a number indicating a specific geographic area. If you choose this option, select an area from the dropdown menu at the bottom of the page.

Some of these areas, such as 01112, have multiple listings. To learn what these numbers represent, reset the search to Specific Locality.

- Specific Locality
  - This search allows you to drill down to specific cities (for example, 0111205 - San Francisco) if payment varies within a MAC for specific localities. Notice the number for San Francisco starts with the Northern California number followed by 05.

- All MACs
  - This option searches for information for the entire nation. The results will include the national payment amount, as well as all MAC localities. This option is helpful for states with multiple payment localities because it groups all localities together for a MAC in case you are interested in how Medicare payment varies by locality within one MAC. However, this option does not provide locality names so it is necessary to know the MAC locality numbers, such as those provided in the Specific Locality option.

Helpful Hint

A MAC will be comprised of more than one of these numbers. For example, the JE MAC includes 01182- Southern California; 01112-Northern California; 01212-Hawaii, Guam, American Samoa, and the Northern Mariana Islands; and 01312-Nevada.

4. Enter the HCPCS code(s) for the search.

5. Select one of the following Modifier options from the dropdown menu:
- Global (Diagnostic Service) OR Physicians Professional Service where Professional/Technical concept does not apply;

- 26 Professional Component;
- 53 Procedures which the physician terminated before completion;
- TC Technical Component; and
- All Modifiers.

Click 'Submit' when all criteria have been selected to begin your Pricing search.

Helpful Hint

If you are uncertain as to which modifier to choose, select 'All Modifiers.' All means all of those modifiers listed above, not all modifiers in the AMA or HCPCS code books.

Pricing Search Using a List of Evaluation/Management Codes

In order to demonstrate the type of information found in a pricing search, this booklet first provides an example of a pricing search using a list of Evaluation/Management (E/M) codes and then shows how the results vary when performing a search using a code with a professional/technical component.

Figure 3 shows the top portion of the Search Results page after selecting or inputting the following information in this order:

- 2016;
- Pricing Information;
- List of HCPCS Codes;
- 11202 South Carolina as the Specific MAC;
- 99214 and 99215 as a list of HCPCS Codes; and
- All Modifiers.

These selections are displayed. In addition, a brief descriptor of each code is provided.

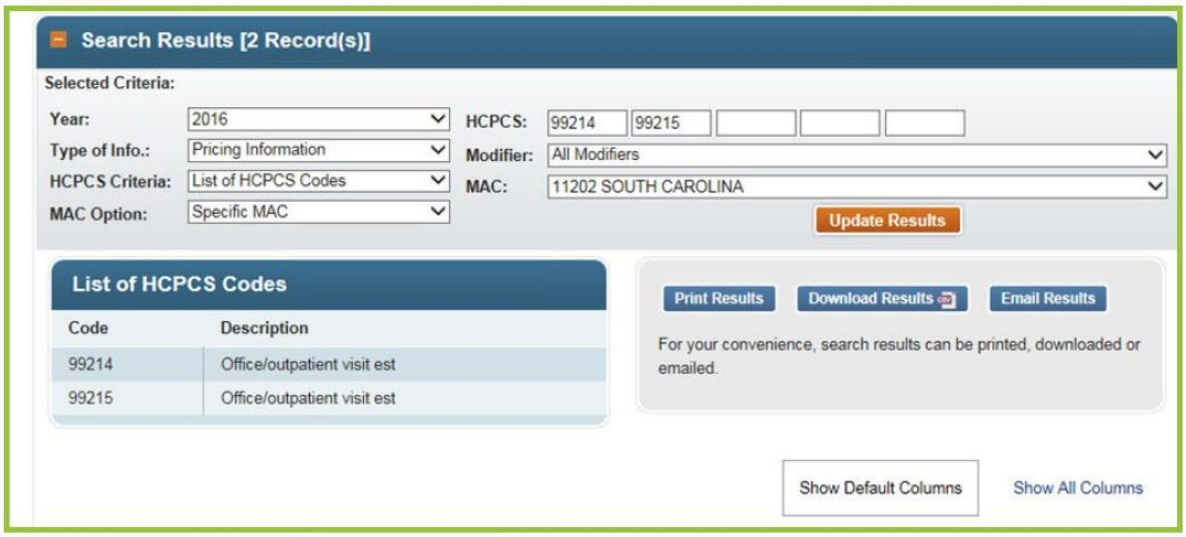


Figure 3: Pricing Search Results for List of E/M Codes

In Figure 3, the 'Show Default Columns' view is automatically selected and only the columns related to the search are shown. To display all fields related to the information, you would select the 'Show All Columns' link.

Helpful Hint

If you wish to change the search criteria, type in a new code or other factor where your choices are indicated at the top of the page and then click on 'Update Results.' You may also print, download, or email your search results by selecting one of these options.

In Figure 4, let's review the pricing information that is provided starting with the column on the left and moving towards the right:

1 HCPCS CODE	2 MODIFIER	3 PROC STAT	4 MAC LOCALITY	5 NON-FACILITY PRICE	6 FACILITY PRICE	7 NON-FACILITY LIMITING CHARGE	8 FACILITY LIMITING CHARGE	9 CONV FACT
99214		A	1120201	$102.63	$76.19	$112.13	$83.23	35.8043
99215		A	1120201	$138.49	$107.80	$151.30	$117.77	35.8043

Figure 4: Pricing Search Results for List of E/M Codes

1. HCPCS Code - 99214 and 99215 are each displayed on a separate row with the pricing information displayed under the columns to the right.

Helpful Hint

If the Single HCPCS Code option had been selected for the search, this column would not have appeared.

2. Modifier - There is nothing displayed in this column.
For services other than those codes with a professional and/or technical component, this field will be blank with one exception: when CPT modifier -53 is allowed, it will appear.

3. PROC STAT - This column includes the Procedure Status Code. In Figure 4, 'A' is listed in this column and indicates an Active Code, which means the code is separately paid under the physician fee schedule if covered.

Helpful Hint

Refer to the "Medicare Claims Processing Manual," IOM Pub. 100-04, Chapter 23, Section

30.2.2, at http://www.cms.gov/manuals/downloads/clm104c23.pdf for full descriptions of all Procedure Status Codes or refer to the Appendix in the back of this booklet.

4. MAC Locality - In Figure 4, 1120201 is displayed.
In this example, '1120201' represents South Carolina, and '01' as the last two digits indicates all of South Carolina's pricing is statewide. If this example was about Northern California, several rows would be displayed because pricing in California varies in several localities.

5. Non-Facility Price - In Figure 4, $102.63 is displayed for 99214 and $138.49 is displayed for 99215.

This column includes the fee schedule amount when a physician performs a procedure in a non-facility setting such as the office. (Non-facility fees are applicable to therapy procedures regardless of whether they are furnished in facility or non-facility settings.)

Occasionally, institutions such as hospitals are under the MPFS. When this occurs, they are paid at the non-facility (higher) rate. Although the terminology might seem confusing at first, the higher payment makes sense because here the facility is responsible for the cost of providing the staff and supplies.

Site of Service Differential

Under the MPFS, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility (such as a hospital) or a non-facility. Generally Medicare provides higher payments to physicians and other health care professionals for procedures performed in their offices because they are responsible for providing clinical staff, supplies, and equipment. This differential is viewed in the NON-FACILITY PRICE and FACILITY PRICE columns.

6. Facility Price - $76.19 is shown for 99214 and $107.80 for 99215.

- This is the fee schedule amount when a physician provides this service in a facility setting, such as a hospital or Ambulatory Surgical Center (ASC).

7. Non-Facility Limiting Charge - $112.13 is shown for 99214 and $151.30 for 99215.

- This is the maximum amount a beneficiary can be charged for the service:
  - By nonparticipating health care professionals;
  - Who do not accept assignment; and
  - When the service is performed in an office setting.

As explained on page 1 of this booklet, there is a 5 percent reduction in the approved amount for nonparticipating health care professionals and suppliers. In other words, the amounts in this column add up to 115 percent of 95 percent of the amounts in column 5.

8. Facility Limiting Charge - $83.23 is shown for 99214 and $117.77 for 99215.

- This is the maximum amount a beneficiary can be charged for the service:
  - By nonparticipating health care professionals;
  - Who do not accept assignment; and
  - When the service is performed in a facility setting.

9. Conv Fact - This column displays the Conversion Factor for this code, which we'll explain later in this booklet, when we discuss RVUs.

Pricing Search Using a Code with an Applicable Professional/Technical Component

Figure 5 below shows the additional pricing information that displays for codes that may be billed globally or with a professional/technical component. The selection criteria for this example were:

- 2016;
- Pricing Information;
- 77057 as the Single HCPCS Code;
- 11202 South Carolina as the Specific MAC; and
- All Modifiers.

	MODIFIER	PROC STAT	MAC LOCALITY	NON-FACILITY PRICE	FACILITY PRICE	NON-FACILITY LIMITING CHARGE	FACILITY LIMITING CHARGE	CONV FACT
1		A	1120201	$77.28	$77.28	$84.43	NA	35.8043
2	26	A	1120201	$34.58	$34.58	$37.78	$37.78	35.8043
3	TC	A	1120201	$42.71	$42.71	$46.66	NA	35.8043

Figure 5: Pricing Search Showing TC and 26

It is important to note that, although the search was only for one code (77057, Mammogram screening), three rows are displayed because there are three ways to bill this code depending whether it is appropriate to bill a modifier.

1. In Figure 5, the first row is blank in the modifier column. When a provider does not use a modifier with this code, it means this provider has performed both the technical and professional components of the procedure. The global pricing amount is $77.28 for the NON-FACILITY PRICE and FACILITY PRICE and
$84.43 for the NON-FACILITY LIMITING CHARGE. NA is shown for the FACILITY LIMITING CHARGE. (These
amounts equal the sum of the amounts in the two other rows under these columns.)

2. The second row provides information for CPT code 77057 submitted with modifier -26, which should be used when only the professional component of the procedure was performed. $34.58 is displayed for the NON-FACILITY PRICE and FACILITY PRICE and $37.78 is shown for the NON-FACILITY LIMITING CHARGE and the FACILITY LIMITING CHARGE.

3. The third row displays the results if the CPT code 77057 is billed with HCPCS Level II modifier TC, Technical Component. TC indicates the claim was billed for the performance of the mammography only, not for the interpretation. $42.71 is displayed under NON-FACILITY PRICE and FACILITY PRICE and $46.66 is shown under NON-FACILITY LIMITING CHARGE. NA is shown for the FACILITY LIMITING CHARGE.

Helpful Hint

For the technical component of certain diagnostic imaging procedures, Medicare payment is based on the lower of the Outpatient Prospective Payment System (OPPS) cap or fee schedule amount; however, payment adjustments are not reflected in the MPFS search results. Full payments are displayed as well as OPPS payments. Also, Multiple Procedures Payment Reductions (MPPRs) cannot be displayed since there are too many combinations of HCPCS codes to consider. For additional information about MPPR, refer to the MLN Matters® articles included in the Resources section of this booklet.

Payment Policy Indicators Search

Let's review the other information available in the searchable MPFS by now using the Payment Policy Indicators Search.

The Payment Policy Indicators include:

- Applicability of professional or technical modifiers;
- The number of post-operative days included in a procedure;
- Whether a code is paid by Medicare;
- The level of physician supervision required; and
- Whether the service can be billed bilaterally.

Payment Policy Indicators Search Using a Code with an Applicable Professional/Technical Component

In Figure 6 we'll search using a code for which there are applicable professional/technical modifiers and then in Figure 7 we'll discuss the information provided when a surgical code is inputted.

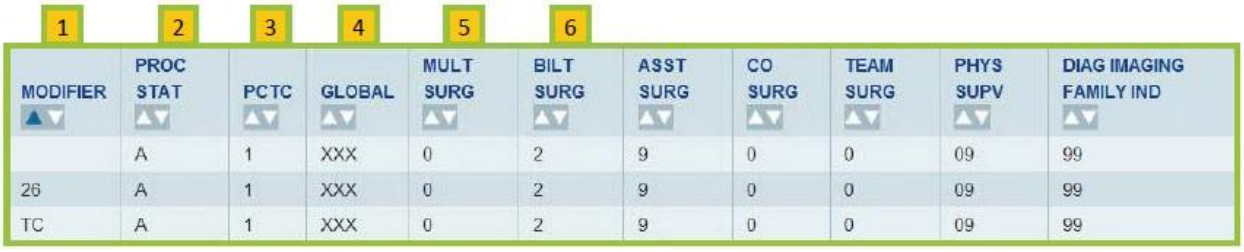
Figure 6 shows a portion of the Search results after selecting the following criteria:

- 2016;
- Payment Policy Indicators;
- Single HCPCS Code 77057; and
- All Modifiers.

We used the same code, 77057, as we just did in a pricing search to compare the information provided.

Helpful Hint

This payment policy search does not request a location or MAC selection because the policies shown are national. Learn more about these policies in the "Medicare Claims Processing Manual," IOM Pub 100-04, Chapter 23, "Fee Schedule Administration and Coding Requirements," at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website. Remember, however, that MACs may have additional, local policies that you'll need to research on their websites or in the Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database on the CMS website.



1 MODIFIER	2 PROC STAT	3 PCTC	4 GLOBAL	5 MULT SURG	6 BILT SURG	ASST SURG	CO SURG	TEAM SURG	PHYS SUPV	DIAG IMAGING FAMILY IND
	A	1	XXX	0	2	9	0	0	09	99
26	A	1	XXX	0	2	9	0	0	09	99
TC	A	1	XXX	0	2	9	0	0	09	99

Figure 6: Payment Policy Indicators Search

1. Modifer – As in our pricing search for this code, the screen displays three rows, showing that code 77057, Mammogram screening, can be reported with no modifier, modifier -26, or a TC modifier.

- All the other columns in this example display the same information for each row under the column heading.

2. Proc Stat – In this column, which shows Procedure Status Indicator, an 'A' is displayed as it was in the Pricing Search, meaning active code.

3. PCTC – This column complements the Modifier column by providing Professional Component/Technical Component Indicators. In our example, '1' is listed, which means the code is a diagnostic test or radiology service. Modifiers -26 and TC may be used when submitting this code on a claim.

4. Global – XXX appears in this example, which means the global surgery concept is not applicable to this code.

5. MULT SURG – There are zeros displayed in this column, which means no payment adjustment rules for multiple procedures apply.

6. BILT SURG – A '2' is displayed, which means the 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (for example, with RT and LT modifiers with a 2 in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code.

For a complete listing of indicators which might appear with other HCPCS code selections, refer to the "Medicare Claims Processing Manual," IOM Pub. 100-04, Chapter 23 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website. In the Addendum, select the layout for the applicable year (such as 2016) or refer to the Appendix in the back of this booklet. In addition, we'll also perform a payment policy search with a surgical example to explain more of these indicators.

All the other columns include indicators showing that these are not applicable or not permitted for code 77057. Let's now do a search using a surgical code to see what type of information may be conveyed in these columns.

Payment Policy Indicators Search Using a Surgical Code

Figure 7 below shows the MPFS search results when searching for CPT code 47480, Incision of gallbladder.

Understanding the information in the columns displayed in these search results helps you understand policies such as bundled procedures or when using an appropriate CPT modifier with a code is necessary in order to be paid appropriately. This includes modifiers for assistant surgeons, bilateral surgery, and multiple procedures.

Figure 7: Payment Policy Indicators Search Using a Surgical Code

1. Modifier – There is no information under the Modifier column.

2. PROC STAT – There is an 'A' in the column indicating this is an active code.

3. PCTC – There is a '0' in the column.

The '0' indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components.

4. Global – This field provides the time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service (as XXX was explained in the previous mammography example).

In Figure 7, '090' is listed, which means code 47480 is major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

5. Mult Surg – This column indicates which payment adjustment rule for multiple procedures (including certain physical therapy procedures) applies to the service. In Figure 7, a '2' indicates that standard payment adjustment rules for multiple procedures apply. Payment is based on the lower of the billed amount, or:

- 100 percent of the fee schedule amount for the highest valued procedure; and
- 50 percent of the fee schedule amount for the second through the fifth highest valued procedures.

Additional procedures are reviewed and considered for payment.

Helpful Hint

When billing for multiple surgeries by the same professional (or physicians in the same group) on the same day, report the primary surgical procedure without modifier -51. Report additional surgical procedures performed by the same professional on the same day with modifier -51. Learn about multiple surgeries in Chapter 12 of IOM Pub. 100-04 and read about modifier -51 in the current CPT code book.

6. BILT SURGERY – This field provides an indicator for bilateral services subject to a payment adjustment. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. In Figure 7, '0' is displayed, which means the 150 percent payment adjustment for bilateral procedures does not apply. If this procedure is reported with modifier
-50 or with modifiers RT and LT, Medicare bases payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.

Helpful Hint

Modifier -50 is a modifier indicating that the procedure was performed bilaterally at the same session. Learn more about billing for bilateral surgery in Chapter 12 of IOM Pub. 100-04 and read about modifier
-50 in the current CPT code book.

7. Asst Surgery – This column indicates whether assistants at surgery may be paid. In Figure 7, '2' is displayed, which means payment restriction for assistants at surgery does not apply to this procedure.

Helpful Hint

Physicians are prohibited from billing a Medicare beneficiary for assistant at surgery services for procedure codes subject to the assistant at surgery limit. Learn more about assistant at surgery payment in Chapter 12 of IOM Pub. 100-04 and review modifiers -AS, -80, -81, and -82 by referring to the CPT/HCPCS code books.

8. CO SURG – This field in Figure 7 includes an indicator '1', which means co-surgeons (each of a different specialty) could be paid. Supporting documentation is required to establish medical necessity of two surgeons for this procedure.

Helpful Hint

Learn more about co-surgeons in Chapter 12 of IOM Pub. 100-04 and read about modifier -62 in the current CPT code book.

9. Team Surg – This field in Figure 7 provides indicator '0' indicating a team of surgeons (more than two surgeons of different specialties) is not permitted for this procedure.

10. Phys Supv – Diagnostic tests, with certain exceptions, must be performed under the supervision of a physician. This field indicates the level of required supervision. In this example, '9' indicates that this concept does not apply.

Relative Value Unit (RVU) and Geographic Practice Cost Index (GPCI) Search

Prior to demonstrating the results of an RVU and GPCI search, it's important to understand what RVUs and GPCIs are. The pricing for each code in the MPFS is based on the following three components:

RVU – RVUs reflect the relative resources required to furnish a physician fee schedule service. Three separate RVUs are associated with the calculation of a payment under the MPFS:

- Work RVUs (reflect the relative time and intensity associated with providing a service and equal approximately 50 percent of the total payment);
- Practice Expense (PE) RVUs (reflect costs such as renting office space, buying supplies and equipment, and staff); and
- Malpractice (MP) RVUs (reflect the relative costs of purchasing malpractice insurance).

RVUs comprise the core of physician fees. CMS provides MACs with the fee schedule RVUs for all services except the following:

- Those with national codes for which national relative values have not been established;
- Those requiring "By Report" payment or MAC pricing; and
- Those that are not included in the definition of physician services.

Review the Status Indicators in the Appendix for more information.

GPCI – To calculate the payment for every physician's service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a GPCI. The GPCIs reflect the relative costs of physician work, practice expense, and malpractice expense in a specific area compared to the national average costs for each component.

Conversion Factor (CF) – Typically, the CF is updated on an annual basis. Until 2015, the annual update was equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compared to a target rate called the Sustainable Growth Rate (SGR). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate (SGR) update formula for payments under the Medicare Physician Fee Schedule. For 2016, the Physician Fee Schedule update factor is 0.5 percent and the CF is 35.8043. RVUs are converted to dollar amounts through the application of the CF.

Further information about RVUs and GPCIs is available in the annual Medicare Physician Fee Schedule Final Rule or the file that can be accessed at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html on the CMS website. In addition, the Medicare

Learning Network® has prepared a fact sheet explaining the RVU payment system. This publication is entitled "Medicare Physician Fee Schedule," and it can be located at http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243670.html on the CMS website.

We'll first demonstrate a RVU search and then show a GPCI search.

RVU Search

Using the Searchable MPFS, we selected:

- 2016;
- Relative Value Units for the Type of Information;
- 99214 for the Single HCPCS Code; and
- All Modifiers.

Figure 8 shows a portion of the screen displayed on the CMS website after making these selections. This figure shows only the following five columns from the many columns displayed on the website because these are the columns of interest to most health care professionals:

- In Figure 8, the WORK RVU column is 1.50.

Helpful Hint

If you searched for code 99215 instead of 99214, there would be a 2.11 in the WORK RVU column indicating a higher relative value. Look back at the pricing search we did earlier in this booklet about these two codes, you'll see that the payment for 99215 is higher than for

99214. This helps you understand the impact of RVUs on the fee schedule amount.

Figure 8: RVU Search

The following Practice Expense (PE) RVUs are displayed in five columns:
1. 1.42 under TRANSITIONED NON-FAC PE RVU;
2. 1.42 under FULLY IMPLEMENTED NON-FAC PE RVU;
3. 0.61 under TRANSITIONED FACILITY PE RVU; and
4. 0.61 under FULLY IMPLEMENTED FACILITY PE RVU.
5. MP RVU (Malpractice RVU) has a value of 0.10 in this example.

Helpful Hint

In order to see how MP RVUs vary, input a different code in an RVU search and compare to this result for 99214.

Chapter 23 of IOM Pub. 100-04, "Medicare Claims Processing Manual," includes information on the other columns that are displayed on the CMS website when doing a RVU search.

GPCI Search

Finally, let's do a GPCI search for 2016. Remember, we do not input a HCPCS code here because the same GPCI applies for all codes in an area. Our choices are whether we want a GPCI for:

- National Payment Amount;
- Specific MAC;
- Specific Locality; or
- All MACs.

Figure 9 displays a portion of the screen for GPCIs when choosing 'All MACs.'

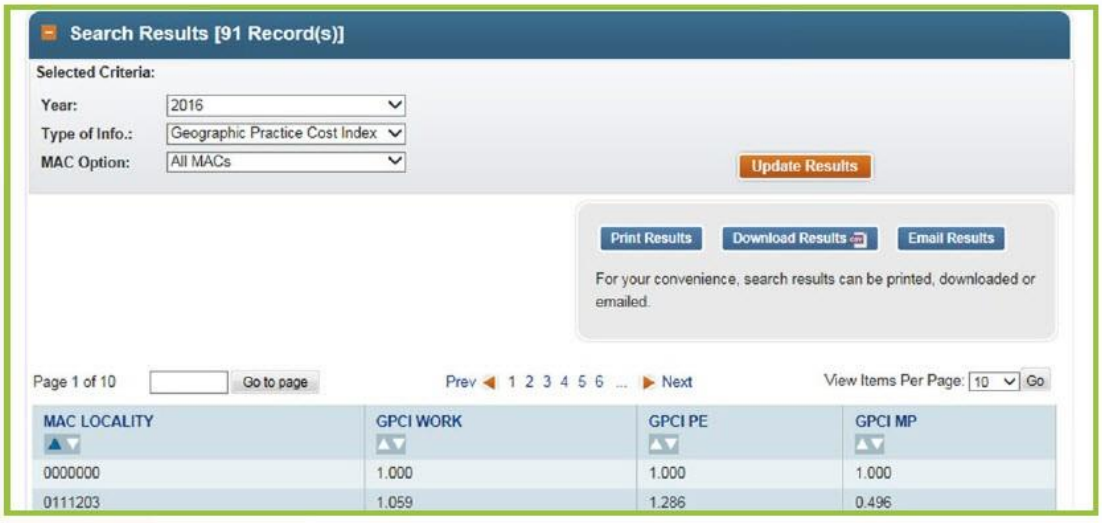


Figure 9: GPCI Search

Remember that MAC Locality 0000000 is national. There is value of '1.000' in each of the three GPCI columns: GPCI WORK, GPCI PE, and GPCI MP. For specific localities, any values higher or lower than '1.000' indicate higher or lower geographic classification values than the national average.

For our example, location 0111203 is displayed with a value of 1.059, 1.286, and 0.496 in these three respective columns.

Conclusion

In this booklet we've shown various types of searches using the searchable MPFS and explained the meaning of the indicators that are displayed as well as some of the policies that are relevant to understanding the information provided in these searches. To obtain further knowledge about the MPFS and related policies, other CMS web pages, provider education articles, and tools are listed in the Resources section of this booklet. You can also print out the "Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide" in this booklet for a step-by-step summary of how to use the MPFS Search Tool.

Resources

Medicare Learning Network® Products

All Available MLN Products

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNProducts/Downloads/MLNCatalog.pdf

The "MLN Catalog" provides users with a list of MLN products that can be downloaded, ordered, or copied free of charge. MLN products include fact sheets, booklets, and more.

"How to Use the Medicare Coverage Database" Booklet

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN- Publications-Items/CMS1247078.html

This booklet is designed to provide education on How to Use the Medicare Coverage Database (MCD). It includes an explanation of the database and how to use the search, indexes and reports, and downloads features.

"How to Use the Medicare National Correct Coding Initiative (NCCI) Tools" Booklet

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN- Publications-Items/CMS1243274.html

This booklet is designed to provide education on how to navigate the CMS NCCI web pages. It includes information on how to look up Medicare code pair edits and medically unlikely edits (MUEs), as well as an explanation of how the NCCI tools can help providers avoid coding and billing errors and subsequent payment denials.

"Medicare Physician Fee Schedule" Fact Sheet

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN- Publications-Items/CMS1243670.html

This fact sheet is designed to provide education on the Medicare Physician Fee Schedule (PFS). It includes the following information: physician services, Medicare PFS payment rates, and Medicare PFS payment rates formula.

MLN Matters® Article MM7442

"Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures" http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM7442.pdf
This article explains that CMS is applying the MPPR to the Professional Component (PC) services as well as to Technical Component (TC) services.

MLN Matters® Article MM7703

"Interaction of the Multiple Procedure Payment Reduction (MPPR) on Imaging Procedures and the Outpatient Prospective Payment System (OPPS) Cap on the Technical Component (TC) of Imaging Procedures"
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM7703.pdf
This article explains that Medicare implemented the MPPR rule on the Technical Component (TC) of certain diagnostic imaging procedures effective January 1, 2006. The MPPR also applies to the Professional Component (PC) of such services effective January 1, 2012.

MLN Matters® Article MM7747

"Application of the Multiple Procedure Payment Reduction (MPPR) on Imaging Services to Physicians in the Same Group Practice"
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM7747.pdf
This article explains that CMS is expanding the MPPR on the Professional Component (PC) and Technical Component (TC) of imaging services by applying it to physicians in the same group practice who furnish multiple services to the same patient, in the same session, on the same day.

MLN Matters® Article MM7848

"Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures"
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/MM7848.pdf
This article explains that CMS is expanding the MPPR policy by applying MPPRs to the TC of diagnostic cardiovascular and ophthalmology procedures.

MLN Matters® Article MM8206

"Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services" http://www.cms.gov/outreach-and-education/medicare-learning-network- mln/mlnmattersarticles/downloads/MM8206.pdf

This article explains that the MPPR on selected therapy services increased to 50 percent for both office and institutional settings for claims with dates of service on or after April 1, 2013.

MLN Matters® Article MM8278

"Applying Multiple Procedure Payment Reductions to Therapy Cap Amounts for Critical Access Hospital (CAH) Claims"
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM8278.pdf
This article is based on Change Request (CR) 8278 which revises the amount applied toward a beneficiary's therapy cap amounts when therapy services are provided in a Critical Access Hospital (CAH).

MLN Matters® Article MM9081

"Emergency Update to the Calendar Year (CY) 2015 Medicare Physician Fee Schedule Database (MPFSDB)"
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/MM9081.pdf
This article is based on Change Request (CR) 9081, to announce an emergency update to payment files issued to contractors based on the CY 2015 MPFS Final Rule. CR9081 amends those payment files, including an updated conversion factor for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from CY 2014 rates.

Provider-Specific Medicare Information

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf
"MLN Guided Pathways: Provider Specific Medicare Resources" helps health care professionals gain knowledge from provider specific resources and products.

Internet-Only Manuals

Internet-Only Manual (IOM) Pub. 100-02 "Medicare Benefit Policy Manual"

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html Chapter 15, "Covered Medical and Other Health Services," includes information on supervision for diagnostic x-ray, laboratory, and other diagnostic tests as well as information about other Medicare Part B covered services.

Internet-Only Manual (IOM) Pub. 100-04 "Medicare Claims Processing Manual"

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html Chapter 1, "General Billing Requirements," includes information on jurisdiction for claims, assignment, participation, termination of provider agreements, billing, and timely filing. This chapter provides information on payment for participating and non-participating providers based on the MPFS.

Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," explains physical therapy and diagnostic and screening mammography services are paid under the MPFS.

Chapter 12, "Physicians/Nonphysician Practitioners," includes information about how CMS updates the MPFS, adjustments to fee schedule components, correct coding policies, and other payment policies.

Chapter 23, "Fee Schedule Administration and Coding Requirements," includes information about coding requirements, edits, and the MPFS. This chapter also identifies services that are paid at reasonable charge rather than based on a fee schedule and discusses the other fee schedules used by CMS, such as the clinical diagnostic laboratory and DMEPOS fee schedules.

CMS Web Pages

CMS Forms

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html
The "Medicare Participating Physician or Supplier Agreement" (Form CMS-460) and other CMS forms can be downloaded from this web page.

Medicare Coverage Database

http://www.cms.gov/medicare-coverage-database
The searchable Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions.

Medicare Physician Fee Schedule Federal Regulation Notices

http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/PFS-Federal- Regulation-Notices.html
This web page lists yearly proposed and final regulations for the MPFS.

National Correct Coding Initiatives (NCCI) Edits

http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. This web page offers a link to the "NCCI Coding Policy Manual for Medicare Services" under the Downloads section.

Physician Fee Schedule

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html This web page provides a link to the annual Physician Fee Schedule (PFS) final rule, files, and various reports. The rule includes annual updates to the relative weights of physician services.

Searchable MPFS

http://www.cms.gov/apps/physician-fee-schedule/overview.aspx
This CMS tool is designed to facilitate searches of information on services covered by the MPFS. It provides Medicare payment information on more than 10,000 physician services, the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment.

Appendix

This information is from the "Medicare Claims Processing Manual," IOM Pub. 100-04, Chapter 23 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
on the CMS website. Select the File Layout for the applicable year from the Addendum.

Helpful Hint

Because this chapter is only updated on an annual basis, it is important to also review MLN Matters® articles and other information from CMS.

Status Indicators

A = Active code. These codes are separately paid under the physician fee schedule, if covered. There will be RVUs and payment amounts for codes with this status. The presence of an 'A' indicator does not mean that Medicare has made a national coverage determination regarding the service; MACs remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a beneficiary).

C = MACs priced code. MACS will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.

E = Excluded from physician fee schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.

I = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90-day grace period.)

M = Measurement codes. Used for reporting purposes only.

N = Non-covered service.

P = Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Social Security Act.

Q = Therapy functional information code. Used for required reporting purposes only.

R = Restricted coverage. Special coverage instructions apply.

T = Paid as only service. These codes are paid only if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not in the statutory definition of 'physician services' for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

Global Surgery

This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

MMM = Maternity codes; usual global period does not apply.

XXX = Global concept does not apply.

YYY = MAC determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = Code related to another service and is always included in the global period of the other

service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Professional Component (PC)/Technical Component (TC) Indicator

0 = Physician service codes. This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers -26 and TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense, and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic tests or radiology services. This indicator identifies codes that describe diagnostic tests (for example, pulmonary function tests or therapeutic radiology procedures such as radiation therapy). These codes generally have both a professional and technical component. Modifiers -26 and TC can be used with these codes. The total RVUs for codes reported with a -26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

2 = Professional component only codes. This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report.

Modifiers -26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 = Technical component only codes. This indicator identifies stand alone codes that describe the technical component (such as staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers -26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 = Global test only codes. This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers -26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

5 = Incident to codes. This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by MACs for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers -26 and TC cannot be used with these codes.

6 = Laboratory physician interpretation codes. This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician, work, practice expense, and malpractice expense.

7 = Private practice therapist's service. Payment may not be made if the service is provided to either a beneficiary in a hospital outpatient department or to an inpatient of the hospital by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

8 = Physician interpretation codes. This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for a hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the Prospective Payment System (PPS) rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 = Concept of a professional/technical component does not apply.

Multiple Procedure (CPT Modifier -51)

This indicator indicates which payment adjustment rule for multiple procedures applies to the service.

0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported

on the same day as another procedure, payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 Medicare Physician Fee Schedule Database (MPFSDB), this indicator only applied to codes with procedure status of 'D.' If a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, Medicare ranks the procedures by the fee schedule amount and the appropriate reduction to this code is applied (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). MACs base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, MACs rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). MACs base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (that is, another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G of the Form CMS-1500 or its electronic equivalent claim. The multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately paid. Payment for the base procedure is included in the payment for the other endoscopy.

4 = Diagnostic imaging services subject to MPPR methodology. TC of diagnostic imaging services subject to a 50 percent reduction of the second and subsequent imaging services furnished by the same physician (or by multiple physicians in the same group practice, for example, same group National Provider Identifier [NPI]) to the same beneficiary on the same day, effective for services July 1, 2010, and after. PC of diagnostic imaging services are subject to a 25 percent payment reduction of the second and subsequent imaging services effective January 1, 2012.

Helpful Hint

Refer to MLN Matters® article MM7442 for information about the 2012 implementation of the

25 percent reduction to the PC for certain diagnostic imaging procedures.

5 = Selected therapy services subject to MPPR methodology. Subject to 20 percent of the practice expense component for certain therapy services furnished in office or other non-institutional settings, and 25 percent reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011, and after). Subject to 50 percent reduction of the practice expense component for certain therapy services furnished in both institutional and non- institutional settings (effective for services April 1, 2013, and after).

6 = Diagnostic cardiovascular services subject to the MPPR methodology. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, that is,

same group National Provider Identifier [NPI]) to the same beneficiary on the same day (effective for services January 1, 2013, and after).

7 = Diagnostic ophthalmology services subject to the MPPR methodology. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 80 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, that is, same group NPI) to the same beneficiary on the same day (effective for services January 1, 2013,
and after).

9 = Concept does not apply.

Bilateral Surgery Indicator (CPT Modifier -50)

This field provides an indicator for services subject to a payment adjustment.

0 = 150 percent payment adjustment for bilateral procedures does not apply. If a procedure is reported with modifier -50 or with modifiers RT and LT, Medicare bases payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100.

Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150 percent payment adjustment for bilateral procedures applies. If a code is billed with the bilateral modifier or is reported twice on the same day by any other means (such as with RT and LT modifiers or with a 2 in the units field), payment is based for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral adjustment is applied before applying any applicable multiple procedure rules.

2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If a procedure is reported with modifier -50 or is reported twice on the same day by any other means (such as with RT and LT modifiers with a 2 in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of
$100 and YYYYY-RT with an actual charge of $100.

Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 = The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (such as with RT and LT modifiers or with a 2 in the units field), Medicare bases payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, the fee schedule amount for a bilateral procedure is determined before applying any applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 = Concept does not apply.

Assistant at Surgery

This field provides an indicator for services where an assistant at surgery is never paid.

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistants at surgery may not be paid.

2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistants at surgery may be paid.

9 = Concept does not apply.

Co-Surgeons (Modifier -62)

This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

0 = Co-surgeons not permitted for this procedure.

1 = Co-surgeons could be paid. Supporting documentation is required to establish medical necessity of two surgeons for the procedure.

2 = Co-surgeons permitted. No documentation is required if two specialty requirements

are met. 9 = Concept does not apply.

Team Surgeons (Modifier -66)

This field provides an indicator for services for which team surgeons may

be paid. 0 = Team surgeons not permitted for this procedure.

1 = Team surgeons could be paid. Supporting documentation is required to establish medical necessity of a team; paid by report.

2 = Team surgeons permitted; pay by
report. 9 = Concept does not apply.

Physician Supervision of Diagnostic Procedures

This field is for use in post payment review.

01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician.

04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist. Otherwise the procedure must be performed under the general supervision of a physician.

05 = Not subject to supervision when furnished personally by a qualified audiologist, physician, or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test.

06 = Procedure must be personally performed by a physician or a Physical Therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision.

21 = Procedure may be performed by a technician with certification under general supervision of a physician. Otherwise the procedure must be performed under direct supervision of a physician.
Procedure may also be performed by a PT with ABPTS certification without physician supervision.

22 = May be performed by a technician with on-line real-time contact with a physician.

66 = May be personally performed by a physician or by a PT with ABPTS certification and certification in this specific procedure.

6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.

77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).

7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.

09 = Concept does not apply.

Diagnostic Imaging Family Indicator

For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated.

01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical)

02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)

04 = Family 4 MRI and MRA (Chest/Abd/Pelvis)

05 = Family 5 MRI and MRA (Head/Brain/Neck)

06 = Family 6 MRI and MRA (Spine)

07 = Family 7 CT (Spine)

08 = Family 8 MRI and MRA (Lower Extremities)

09 = Family 9 CT and CTA (Lower Extremities)

10 = Family 10 Mr and MRI (Upper Extremities and Joints)

11 = Family 11 CT and CTA (Upper Extremities)

88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of the PC diagnostic imaging (effective for services January 1, 2012, and after).

99 = Concept Does Not Apply.

Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide

Locate the MPFS Search Tool at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx and follow the steps below to complete the MPFS search process.

Step 1: Year

Select the MPFS year for your search.

Step 2: Type of Information

Select one of the following five types of information relevant to your search:

- Pricing Information;
- Payment Policy Indicators;
- Relative Value Units (RVUs);
- Geographic Practice Cost Index (GPCI); or
- All.

Step 3: Healthcare Common Procedure Coding System (HCPCS) Criteria

Select one of the following three options (this step will not appear if the GPCI Type of Information option was selected in step 2 above):

- Single HCPCS Code – After selecting this option, indicate the code in the HCPCS Code field that will appear at the bottom of the page;
- List of HCPCS Codes – After selecting this option, enter up to five codes in the HCPCS Code fields that will appear at the bottom of the page; or
- Range of HCPCS Codes – After selecting this option, enter starting and ending procedure codes for the code range in the HCPCS Code fields that will appear at the bottom of the page. Note:
  Using a small range of codes is recommended. The response time will be slower for a larger range. Then, select a modifier value from the Modifier dropdown menu at the bottom of the page.

Step 4: Medicare Administrative Contractor (MAC)

Select one of the following four options (this step will only appear if Pricing Information, GPCI, or All was selected for the Type of Information in step 2):

- National Payment Amount – This amount is designated with a MAC locality code of '0000000';
- Specific MAC – After selecting this option, indicate the MAC of your interest from the MAC dropdown menu that will appear at the bottom of the page;
- Specific Locality – After selecting this option, select the locality of your interest from the MAC Locality dropdown menu that will appear at the bottom of the page; or
- All MACs – Displays information for the entire nation (results will include the national payment amount, as well as all MAC localities).

Step 5: Click Submit to view your search results.

Disclaimers

This educational product was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This educational product was prepared as a service to the public and is not intended to grant rights or impose obligations. This educational product may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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Occupational Therapy

Introduction

The initial evaluation occurs during the patient's initial encounter with the Therapist. During the evaluation, the therapist spends time collecting information including medical history, detailed prior level of function, current problems or complaints, how this is impacting daily activities or functional limitations. The evaluation process also includes collecting objective information including but not limited to ROM, MMT, pain, sensation, functional assessment (transfers/ambulation/activities of daily living), cognitive status, problem-solving ability, learning potential, communication skills, and swallowing abilities. The assessment involves rating the patient's ability to perform various tasks. Attached links are sample evaluations for Occupational Therapy, including rating scales.

Documentation of a visit or encounter, often called a **daily note or treatment encounter note**, documents the implementation of the Plan of Care established by the therapist. The note should incorporate changes in patient status, a description and progressions of specific interventions used that may be documented in a flow sheet format. Regardless of the format, it is important to convey in the documentation that the interventions provided require the skills, knowledge and judgment of a therapist. Demonstration of skilled care includes documenting the type and level of skilled assistance given to the patient, clinical decision making, and ongoing analysis of patient progress. This can be expressed by recording both the type and amount of manual, visual, and/or verbal cues used by the therapist to assist the patient in completing the exercise/activity completely and correctly. It can also be illustrated by documenting the clinical rationale for selecting the interventions and/or why the interventions are still deemed necessary. Completing a treatment grid is one method of tracking treatments/visits with regard to the specific treatment rendered and time spent on each intervention. Attached links are sample daily notes and treatment grids for Occupational Therapy.

Progress notes should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can occur during treatment. The reasons for lack of progress should be noted and the justification for continued treatment be documented if treatment is planned to continue after regression or plateaus. The minimum progress report period shall be at least once every 10 treatment days. In some settings, weekly progress reports are voluntarily prepared to review progress, describe the skilled treatment, and update goals. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary. Harmony Healthcare has always maintained that weekly progress notes provide the optimal means of demonstrating the need for and provision of daily skilled care. The note should incorporate professional judgment regarding the need for continued services. Goals and/or treatment should be modified or upgraded accordingly. Attached links are sample progress notes for Occupational Therapy.

Discharge Summary is written at the conclusion of a patient's care. The summary is a synopsis of what occurred from the time of the initial evaluation through the final treatment session. A comparison of the status between the time of the initial encounter with the patient and the final encounter should be present. All skilled interventions/techniques provided during episode of care should be included. Attached links are sample progress discharge summaries for Occupational Therapy.

Occupational Therapy

Rating Scale

Rating Scale	I	S	MIN	MOD	MAX	TOTAL
Eating – Bring food to mouth/uses utensils **Grooming –** Oral, Hair washing	Independent	Supervise, cues set-up or minimal assistance	PT performs 75%+ of task	PT performs 50-74% of tasks	PT performs 25-49% of task	Total assist
Dressing-Upper (and undressing) **Dressing-Lower** (and undressing)	Independent	Supervise, cues set-up or minimal assistance	PT performs 75%+ of task	PT performs 50-74% of task	PT performs 25-49% of tasks	Total assist
Endurance Status/Stamina Ability to tolerate/sustain normal daily routines without symptoms (fatigue, dyspnea, palpitations or pain)	Tolerates activity for 30 minutes	Tolerates activity for 10+ minutes	Tolerates activity for 5+ minutes	Comfortable at rest, tolerates activity for less than 5 minutes	Comfortable at rest, activity causes symptoms	Symptoms at rest, activity increases distress
Cognitive Status Accurate attention, memory function	No problem	Occasional direction req. memory difficulty	Often direction required in some situations	Frequent direction required in several situations	Consistently needs direction	Total dependence coma, vegetative state, delirium, acute psychotic episode
Problem Solving Reasonable, safe, timely decisions	Independent, appropriate decisions	Standby prompting, cues in stressful or unfamiliar conditions	Solves routine problems 75-90%	Solves routine problems 50-74%	Solves routine problems 25-49%	Total assist, solves problems <25%
Learning Potential Ability to incorporate learned skills into daily living	Learns w/o limitations	Requires assistance under stressful conditions less than 10% of time	Occasional repetition or simplification	Frequent assistance or guidance	Seriously interferes and limits functions	Limited-complete dependence
Meal Preparation & Clean-up	Independent, no special treatment	Set-up required or infrequent assist	PT performs 75%+ of task	PT performs 50-74%. Verbal or physical assist to complete	PT performs 25-49%. Verbal or physical assist to complete	Total assist

Key: Strength

5/5	=	Normal	2/5	=	Poor
4/5	=	Good	1/5	=	Trace
3/5	=	Fair	0/5	=	Zero

Key: Level of Independence

I	=	Independent	MOD	=	Moderate Assist (performs 50%-74%)
S	=	Supervision/Set-up (performs 90% or more)	MAX	=	Maximum Assist (performs 25%-49%)
MIN	=	Minimum Assist (performs 75%-89%)	TOTAL	=	Total Assist (less than 24%)

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430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-3738
www.harmony-healthcare.com

Occupational Therapy

Narrative Progress Notes

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature

Patient Name _____ Room # _____

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www.harmony-healthcare.com

Occupational Therapy

Date Time	Prob. No.	All Entries Shall Be Signed With Name and Title

Therapy Notes

_____ Physical Therapy

_____ Occupational

_____ Speech

Doctor:

File #:

Room #:

Patient:

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www.harmony-healthcare.com

Occupational Therapy

Progress Flow Sheet

Patient Name: _____ Room #: _____
Diagnosis: _____ Admission Date: _____
ICD-10 Code:_____ Frequency/Duration: _____
Payer Source: _____ Expected D/C Date: _____
Med A Med B Medicaid HMO: _____ Primary Therapist: _____

	Date	Date	Date	Date	Date	Date
UE Bathe						
LE Bathe						
UE Dress						
LE Dress						
Grooming						
Feeding						
Toilet Transfer						
Tub Transfer						
Minutes:						
Therapist's Initials:						

Comments:

_____

_____

_____

Therapist's Signature: _____

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION

(COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME	FIRST NAME M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.

12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS *(Short Term)* OUTCOME *(Long Term)*	PLAN
13. SIGNATURE *(professional establishing POC including prof. designation)*	14. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*
I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐ N/A 15. PHYSICIAN SIGNATURE — 16. DATE	17. CERTIFICATION FROM THROUGH N/A 18. ON FILE *(Print/type physician's name)* ☐
20. INITIAL ASSESSMENT *(History, medical complications, level of function at start of care. Reason for referral.)*	19. PRIOR HOSPITALIZATION FROM TO N/A

21. FUNCTIONAL LEVEL *(End of billing period)* PROGRESS REPORT ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

	22. SERVICE DATES FROM THROUGH

Form CMS-700-(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-700

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000)*.
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider.
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.
7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).
8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAME.
11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*
12. **Plan of Treatment/Functional Goals** - Enter brief current plan of treatment goals for the patient for this billing period. Enter the major short-term goals to reach overall long-term outcome. Enter the major plan of treatment to reach stated goals and outcome. Estimate time-frames to reach goals, when possible.
13. **Signature** - Enter the signature *(or name)* and the professional designation of the professional establishing the plan of treatment.
14. **Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
15. **Physician's Signature** - If the form CMS-700 is used for certification, the physician enters his/her signature. **If certification is required and the form is not being used for certification, check the ON FILE box in item 18.** If the certification is not required for the type service rendered, check the N/A box.
16. **Date** - Enter the date of the physician's signature only if the form is used for certification.
17. **Certification** - Enter the inclusive dates of the certification, **even if the ON FILE box is checked in item 18.** Check the N/A box if certification is not required.
18. **ON FILE** (Means certification signature and date) - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If certification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
19. **Prior Hospitalization** - Enter the inclusive dates of recent hospitalization *(1st to DC day)* **pertinent** to the patient's current plan of treatment. Enter N/A if the hospital stay does not relate to the rehabilitation being rendered.
20. **Initial Assessment** - Enter only **current relevant history** from records or patient interview. Enter the major functional limitations stated, if possible, in objective measurable terms. Include only relevant surgical procedures, prior hospitalization and/or therapy for the same condition. Include only pertinent baseline tests and measurements from which to judge future progress or lack of progress.
21. **Functional Level** (end of billing period) - Enter the pertinent progress made and functional levels obtained at the end of the billing period compared to levels shown on initial assessment. Use objective terminology. Date progress when function can be consistently performed. When only a few visits have been made, enter a note indicating the training/treatment rendered and the patient's response if there is no change in function.
22. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of CMS-700 or 701 is required.)

1. PATIENT'S LAST NAME FIRST NAME M.I.		2. PROVIDER NO.	3. HICN
4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
	12. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*		

13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify changes to goals and plan.)*

GOALS *(Short Term)*	PLAN
OUTCOME *(Long Term)*	

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ N/A ☐ DC	14. RECERTIFICATION FROM THROUGH N/A

15. PHYSICIAN'S SIGNATURE	16. DATE	17. ON FILE *(Print/type physician's name)* ☐

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care.)*

19. SIGNATURE *(or name of professional, including prof. designation)*	20. DATE	21. ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(At end of billing period — Relate your documentation to functional outcomes and list problems still present.)*

22. SERVICE DATES FROM THROUGH

Form CMS-701(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-701

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000)*.
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider. *(This is an item which you may enter for your own records.)*
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.
7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).
8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAMPLE.
11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*
12. **Current Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
13. **Current Plan Update, Functional Goals** - Enter the current plan of treatment goals for the patient for this billing period. *(If the same as shown on the CMS-700 or previous 701 enter "same".)* Enter the short-term goals to reach overall long-term outcome. Justify intensity if appropriate. Estimate time-frames to meet goals, when possible.
14. **Recertification** - Enter the inclusive dates when recertification is required, **even if the ON FILE box is checked in item 17.** Check the N/A box if recertification is not required for the type of service rendered.
15. **Physician's Signature** - If the form CMS-701 is used for recertification, the physician enters his/her signature. If recertification is not required for the type of service rendered, check N/A box. **If the form CMS-701 is not being used for recertification, check the ON FILE box - item 17.** If discharge is ordered, check DC box.
16. **Date** - Enter the date of the physician's signature only if the form is used for recertification.
17. **On File** *(Means certification signature and date)* - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If recertification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
18. **Reason(s) For Continuing Treatment This Billing Period** - Enter the **major reasons** why the patient needs to continue skilled rehabilitation **for this billing period** (e.g., briefly state the patient's need for specific functional improvement, skilled training, reduction in complication or improvement in safety and how long you believe this will take, if possible or state your reasons for recommending discontinuance). Complete by the rehab specialist prior to physician's recertification.
19. **Signature** - Enter the signature *(or name)* and the professional designation of the individual justifying or recommending need for care *(or discontinuance)* for this billing period.
20. **Date** - Enter the date of the rehabilitation professional's signature.
21. Check the box if services are continuing or discontinuing at end of this billing period.
22. **Functional Level** *(end of billing period)* - Enter the pertinent progress made through the end of this billing period. Use objective terminology. Compare progress made to that shown on the previous CMS-701, item 22, or the CMS-700, items 20 and 21. Date progress when function can be consistently performed or when meaningful functional improvement is made or when significant regression in function occurs. Your intermediary reviews this progress compared to that on the prior CMS-701 or 700 to determine coverage for this billing period. Send a photocopy of the form covering the previous billing period.
23. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

Occupational Therapy

Weekly Progress Note

Date: _____

ADL	IND	SBA	MIN	MOD	MAX	DEP	Adaptive Equipment
Self-Feeding							
Grooming							
Hygiene							
UB Dressing							
LB Dressing							
Functional Transfer							
Toilet Cl. Mgt							
Toileting Hygiene							
UB Bathing							
LB Bathing							
Function Mobility							
Coordination	**Good**			**Fair**			**Poor**
Fine							
Gross							
Balance	**Good**			**Fair**			**Poor**
Sitting							
Standing							
Cognition	**Good**			**Fair**			**Poor**
Safety							
Sequencing							
Prob. Solving							
Working Memory							
Visual Perception	**Good**			**Fair**			**Poor**
UE Strength	**Good**			**Fair**			**Poor**
Right							
Left							
AROM:							
PROM:							

Barriers to Function			
	Improved	No Change	Declined
Cognition			
Endurance			
Skin Integrity			
Strength			
Pain			
Edema			
Visual-Perceptual			
Positioning			

Other:

Comments:

Skilled Services:

Function Impairment Remaining:

Function Improvement:

Updated Goals

Therapist Signature	**Date**
Patient Name	**HICN**	**Room Number**

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Occupational Therapy

Occupational Therapy Weekly Notes

Resident Name: _____ Service Dates: From _____To_____

	Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Goals
Functional Tasks	Date:								
	Goals								Goal Met Date Met
									Y N
									Y N
									Y N
									Y N
									Y N
Initials									

Signature	Title	Initials

Documented reason in note: E = Evaluation W = Withheld R =Refused

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Occupational Therapy

Occupational Therapy Weekly Notes
(continued)

Resident Name: _____ Service Dates: From _____To_____

Weekly Assessment: (Include patient's response to treatment and skilled intervention provided)	
Plan for Revised Goals: (Include reason for continued skilled services)	**Risks/Safety Concerns:** (Functional impairments remained / barriers to achieving goals)
	Anticipated Discharge Date: **Location:**
Signature:	Date:

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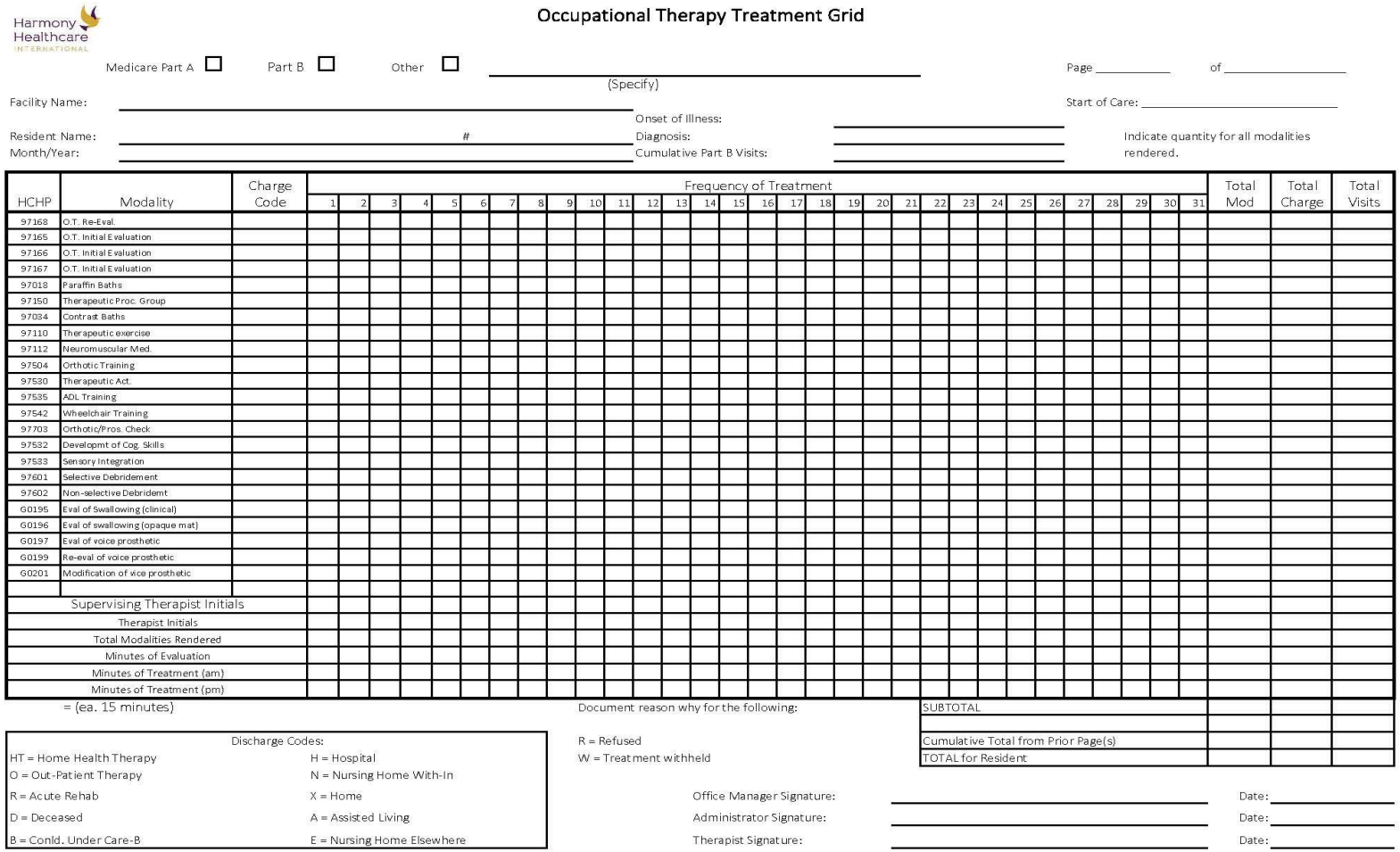
Occupational Therapy



Harmony Healthcare INTERNATIONAL

Occupational Therapy Treatment Grid

Medicare Part A ☐ Part B ☐ Other ☐ _____ (Specify) Page _____ of _____

Facility Name: _____ Start of Care: _____

Resident Name: _____ # _____ Onset of Illness: _____

Month/Year: _____ Diagnosis: _____

Cumulative Part B Visits: _____

Indicate quantity for all modalities rendered.

HCHP	Modality	Charge Code	Frequency of Treatment 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Mod	Total Charge	Total Visits
97168	O.T. Re-Eval.																																			
97165	O.T. Initial Evaluation																																			
97166	O.T. Initial Evaluation																																			
97167	O.T. Initial Evaluation																																			
97018	Paraffin Baths																																			
97150	Therapeutic Proc. Group																																			
97034	Contrast Baths																																			
97110	Therapeutic exercise																																			
97112	Neuromuscular Med.																																			
97504	Orthotic Training																																			
97530	Therapeutic Act.																																			
97535	ADL Training																																			
97542	Wheelchair Training																																			
97703	Orthotic/Pros. Check																																			
97532	Developmt of Cog. Skills																																			
97533	Sensory Integration																																			
97601	Selective Debridement																																			
97602	Non-selective Debridemt																																			
G0195	Eval of Swallowing (clinical)																																			
G0196	Eval of swallowing (opaque mat)																																			
G0197	Eval of voice prosthetic																																			
G0199	Re-eval of voice prosthetic																																			
G0201	Modification of vice prosthetic																																			
	Supervising Therapist Initials																																			
	Therapist Initials																																			
	Total Modalities Rendered																																			
	Minutes of Evaluation																																			
	Minutes of Treatment (am)																																			
	Minutes of Treatment (pm)																																			

= (ea. 15 minutes)

Document reason why for the following:

R = Refused

W = Treatment withheld

SUBTOTAL			
Cumulative Total from Prior Page(s)			
TOTAL for Resident			

Discharge Codes:

HT = Home Health Therapy	H = Hospital
O = Out-Patient Therapy	N = Nursing Home With-In
R = Acute Rehab	X = Home
D = Deceased	A = Assisted Living
B = Conld. Under Care-B	E = Nursing Home Elsewhere

Office Manager Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Occupational Therapy

Monthly Summary and Recertification

MED A ☐ OTHER DATE:

Patient Last Name:_____ First Name:_____ Provider #: _____

Precautions:_____ Onset Date: _____ SOC Date: Frequency/Duration: _____

Functional Task	Initial Goals	Initial/Start Status	Current Status	Updated/New Goals

Monthly Summary: (Include skilled intervention, provided patient's response to treatment and reason for continuing treatment)

Plan of Treatment

- ☐ Therapeutic Activities
- ☐ Therapeutic Exercise
- ☐ ADL/Self Care
- ☐ Other
- ☐ Neuromuscular
- ☐ Orthotic
- ☐ Wheelchair
- ☐ Group

Signature/Title_____ Date: _____

I certify the need for these services furnished under this plan of treatment and while under my care.

Certification from _____ through _____

Physicians Signature_____Date: _____

☐ Continue Service ☐ DC Service

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Physical Therapy

Introduction

The **initial evaluation** occurs during the patient's initial encounter with the Therapist. During the evaluation, the therapist spends time collecting information including medical history, detailed prior level of function, current problems or complaints, how this is impacting daily activities or functional limitations. The evaluation process also includes collecting objective information including but not limited to ROM, MMT, pain, sensation, functional assessment (transfers/ambulation/activities of daily living), cognitive status, problem-solving ability, learning potential, communication skills, and swallowing abilities. The assessment involves rating the patient's ability to perform various tasks. Attached links are sample evaluations for Physical Therapy, including rating scales.

Documentation of a visit or encounter, often called a **daily note or treatment encounter note**, documents the implementation of the Plan of Care established by the therapist. The note should incorporate changes in patient status, a description and progressions of specific interventions used that may be documented in a flow sheet format. Regardless of the format, it is important to convey in the documentation that the interventions provided require the skills, knowledge and judgment of a therapist. Demonstration of skilled care includes documenting the type and level of skilled assistance given to the patient, clinical decision making, and ongoing analysis of patient progress. This can be expressed by recording both the type and amount of manual, visual, and/or verbal cues used by the therapist to assist the patient in completing the exercise/activity completely and correctly. It can also be illustrated by documenting the clinical rationale for selecting the interventions and/or why the interventions are still deemed necessary. Completing a treatment grid is one method of tracking treatments/visits with regard to the specific treatment rendered and time spent on each intervention. Attached links are sample daily notes and treatment grids for Physical Therapy.

Progress notes should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can occur during treatment. The reasons for lack of progress should be noted and the justification for continued treatment be documented if treatment is planned to continue after regression or plateaus. The minimum progress report period shall be at least once every 10 treatment days. In some settings, weekly progress reports are voluntarily prepared to review progress, describe the skilled treatment, and update goals. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary. Harmony Healthcare has always maintained that weekly progress notes provide the optimal means of demonstrating the need for and provision of daily skilled care. The note should incorporate professional judgment regarding the need for continued services. Goals and/or treatment should be modified or upgraded accordingly. Attached links are sample progress notes for Physical Therapy.

Discharge Summary is written at the conclusion of a patient's care. The summary is a synopsis of what occurred from the time of the initial evaluation through the final treatment session. A comparison of the status between the time of the initial encounter with the patient and the final encounter should be present. All skilled interventions/techniques provided during episode of care should be included. Attached links are sample progress discharge summaries for Physical Therapy.

Physical Therapy

Rating Scale

Rating Scale	I	S	MIN	MOD	MAX	TOTAL
Pain Pain interference with function	No problem	Mild interference <10% of time	Functions 75-90% of time	Functions 50-74% of time	Functions 25-49% of time	Severely limits function
Bed Mobility; Transfer-Bed Toilet; Bathing; Car	Independent	Supervise/cues 75%+ assistance	PT performs 50-74% of task	PT performs 25-49% of tasks	PT performs assist of task	Total
Wheel Chair Management Control and independence	Wheelchair dependent but controls independently	Cueing, supervision or minimal assist required, required even for short distances	Capable of performing up to 75%+ of effort	Capable of performing up to 50-74% of effort	Another controls, but contributes up to 50% of effort	No purposeful contribution
Walking – Short Walk once standing	Walks alone 50 feet or more	Walks alone up to 50' with occasional support/ leaning or supervision	Walks alone up to 25' with some support/ leaning, appliance, may be used	Walks alone up to 25' with constant support/ leaning, appliance may be used	Walks w/helper to 25' with constant support/ leaning, appliance may be used	Not able to walk at least 10 feet even with support/ helper
Walking – Long Walk once standing 150 feet minimum	Walks 150' independently	Walks 150' Requires standby, supervision/ cueing	Supervision, set-up or cueing walk min of 150' PT performs 75%+ of effort	Supervision, set-up or cueing walk min of 150' PT performs 50-74% of effort	Supervision, set-up or cueing walk min of 50' PT performs 25-49% of effort	PT performs <25% or gets <50'
Stair Climbing One flight (6-8 steps) up and down	Independent	4-6 stairs w/ or w/o device or requires supervis/cues for one flight	PT performs 75%+ of effort	PT performs 50-74%	PT performs 25-49% of effort or 4-6 stairs w/1 person assist	Total assist
Ambulation Equipment Used most during waking hours	No device	Quad Cane/ Hemi Walker	2 canes or crutches	Walker, rolling	Walker, non-rolling	Unable to walk, even with devices
Elevation Activities Negotiates curbs, ramps or a single stair; appropriate for goal setting	Completely Independent	Req. stand-by supervision, cueing	PT performs 75% or more	PT performs 50-74%	1 or 1+ person assist; patient contributes up to 40%	Unable to perform

Key: Strength

5/5 = Normal 2/5 = Poor
4/5 = Good 1/5 = Trace
3/5 = Fair 0/5 = Zero

Key: Balance

4/4 = normal (good balance responses bilat) 1/4 = poor (cannot maintain posture)
3/4 = good (accepts mild challenges w/o LOB) 0/4 = absent (needs full support)
2/4 = fair (maintains posture w/asst)

Key: Level of Independence

I = Independent
S = Supervision/Set-up (performs 90% or more)
MIN = Minimum Assist (performs 75%-89%)
MOD = Moderate Assist (performs 50%-74%)
MAX = Maximum Assist (performs 25%-49%)
TOTAL = Total Assist (less than 24%
N/A = Not applicable

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Narrative Progress Notes

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature

Patient Name _____ Room # _____

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Physical Therapy

Date Time	Prob. No.	All Entries Shall Be Signed With Name and Title

Therapy Notes

_____ Physical Therapy

_____ Occupational

_____ Speech

Doctor:

File #:

Room #:

Patient:

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Physical Therapy

Progress Flow Sheet

Patient Name: _____ Room #: _____
Diagnosis: _____ Admission Date: _____
ICD-10 Code:_____ Frequency/Duration: _____
Payer Source: _____ Expected D/C Date: _____
Med A Med B Medicaid HMO: _____ Primary Therapist: _____

	Date	Date	Date	Date	Date	Date
Rolling						
Supine to Sit						
Site to Supine						
Sit to Stand						
Stand to Sit						
Transfers						
Ambulation Distance						
Ambulation Device						
Ambulation Assist						
Stairs						
W/C Management						
W/C Propulsion						
Education/ D/C Planning						
Minutes						
Therapist's Initials:						

Comments:

_____

_____

_____

Therapist's Signature: _____

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION

(COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME	FIRST NAME M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.

12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS *(Short Term)* OUTCOME *(Long Term)*	PLAN
13. SIGNATURE *(professional establishing POC including prof. designation)*	14. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*
I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐ N/A 15. PHYSICIAN SIGNATURE — 16. DATE	17. CERTIFICATION FROM THROUGH N/A 18. ON FILE *(Print/type physician's name)* ☐
20. INITIAL ASSESSMENT *(History, medical complications, level of function at start of care. Reason for referral.)*	19. PRIOR HOSPITALIZATION FROM TO N/A

21. FUNCTIONAL LEVEL *(End of billing period)* PROGRESS REPORT ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

	22. SERVICE DATES FROM THROUGH

Form CMS-700-(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-700

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000)*.
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider.
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.
7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).
8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAME.
11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*
12. **Plan of Treatment/Functional Goals** - Enter brief current plan of treatment goals for the patient for this billing period. Enter the major short-term goals to reach overall long-term outcome. Enter the major plan of treatment to reach stated goals and outcome. Estimate time-frames to reach goals, when possible.
13. **Signature** - Enter the signature *(or name)* and the professional designation of the professional establishing the plan of treatment.
14. **Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
15. **Physician's Signature** - If the form CMS-700 is used for certification, the physician enters his/her signature. **If certification is required and the form is not being used for certification, check the ON FILE box in item 18.** If the certification is not required for the type service rendered, check the N/A box.
16. **Date** - Enter the date of the physician's signature only if the form is used for certification.
17. **Certification** - Enter the inclusive dates of the certification, **even if the ON FILE box is checked in item 18.** Check the N/A box if certification is not required.
18. **ON FILE** (Means certification signature and date) - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If certification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
19. **Prior Hospitalization** - Enter the inclusive dates of recent hospitalization *(1st to DC day)* **pertinent** to the patient's current plan of treatment. Enter N/A if the hospital stay does not relate to the rehabilitation being rendered.
20. **Initial Assessment** - Enter only **current relevant history** from records or patient interview. Enter the major functional limitations stated, if possible, in objective measurable terms. Include only relevant surgical procedures, prior hospitalization and/or therapy for the same condition. Include only pertinent baseline tests and measurements from which to judge future progress or lack of progress.
21. **Functional Level** (end of billing period) - Enter the pertinent progress made and functional levels obtained at the end of the billing period compared to levels shown on initial assessment. Use objective terminology. Date progress when function can be consistently performed. When only a few visits have been made, enter a note indicating the training/treatment rendered and the patient's response if there is no change in function.
22. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of CMS-700 or 701 is required.)

1. PATIENT'S LAST NAME	FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN

4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE

8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
	12. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*		

13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify changes to goals and plan.)*

GOALS *(Short Term)* OUTCOME *(Long Term)*	PLAN

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ N/A ☐ DC	14. RECERTIFICATION FROM THROUGH N/A

15. PHYSICIAN'S SIGNATURE	16. DATE	17. ON FILE *(Print/type physician's name)* ☐

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care.)*

19. SIGNATURE *(or name of professional, including prof. designation)*	20. DATE	21. ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(At end of billing period — Relate your documentation to functional outcomes and list problems still present.)*

22. SERVICE DATES FROM THROUGH

Form CMS-701(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-701

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000)*.
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider. *(This is an item which you may enter for your own records.)*
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.
7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).
8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAMPLE.
11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*
12. **Current Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
13. **Current Plan Update, Functional Goals** - Enter the current plan of treatment goals for the patient for this billing period. *(If the same as shown on the CMS-700 or previous 701 enter "same".)* Enter the short-term goals to reach overall long-term outcome. Justify intensity if appropriate. Estimate time-frames to meet goals, when possible.
14. **Recertification** - Enter the inclusive dates when recertification is required, **even if the ON FILE box is checked in item 17.** Check the N/A box if recertification is not required for the type of service rendered.
15. **Physician's Signature** - If the form CMS-701 is used for recertification, the physician enters his/her signature. If recertification is not required for the type of service rendered, check N/A box. **If the form CMS-701 is not being used for recertification, check the ON FILE box - item 17.** If discharge is ordered, check DC box.
16. **Date** - Enter the date of the physician's signature only if the form is used for recertification.
17. **On File** *(Means certification signature and date)* - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If recertification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
18. **Reason(s) For Continuing Treatment This Billing Period** - Enter the **major reasons** why the patient needs to continue skilled rehabilitation **for this billing period** (e.g., briefly state the patient's need for specific functional improvement, skilled training, reduction in complication or improvement in safety and how long you believe this will take, if possible or state your reasons for recommending discontinuance). Complete by the rehab specialist prior to physician's recertification.
19. **Signature** - Enter the signature *(or name)* and the professional designation of the individual justifying or recommending need for care *(or discontinuance)* for this billing period.
20. **Date** - Enter the date of the rehabilitation professional's signature.
21. Check the box if services are continuing or discontinuing at end of this billing period.
22. **Functional Level** *(end of billing period)* - Enter the pertinent progress made through the end of this billing period. Use objective terminology. Compare progress made to that shown on the previous CMS-701, item 22, or the CMS-700, items 20 and 21. Date progress when function can be consistently performed or when meaningful functional improvement is made or when significant regression in function occurs. Your intermediary reviews this progress compared to that on the prior CMS-701 or 700 to determine coverage for this billing period. Send a photocopy of the form covering the previous billing period.
23. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

Physical Therapy

Physical Therapy Weekly Notes

Resident Name: _____ Service Dates: From _____To_____

	Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Goals
Functional Tasks	Date:								
	Goals								Goal Met Date Met
									Y N
									Y N
									Y N
									Y N
									Y N
	Initials								

Signature	Title	Initials

Documented reason in note: E = Evaluation W = Withheld R =Refused

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Physical Therapy

Physical Therapy Weekly Notes
(continued)

Resident Name: _____ Service Dates: From _____To_____

Weekly Assessment: (Include patient's response to treatment and skilled intervention provided)	
Plan for Revised Goals: (Include reason for continued skilled services)	**Risks/Safety Concerns:** (Functional impairments remained / barriers to achieving goals)
	Anticipated Discharge Date: **Location:**
Signature:	Date:

Physical Therapy

Physical Therapy Treatment Grid

Medicare Part A Part B Other _____ (Specify) Page _____ of _____

Facility Name: _____ Start of Care: _____

Resident Name : _____ # _____ Onset of Illness: _____

Month/Year: _____ Diagnosis: _____

Cumulative Part B Visits: _____

Indicate quantity for all modalities rendered.

R = Refused

HCHP	Modality	Charge Code	Frequency of Treatment 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	Total	Total
97001	P.T. Initial Evaluation																																			
97002	P.T. Re-evaluation																																			
97018	Paraffin Baths																																			
97150	Therapeutic Proc. Group																																			
97034	Contrast Baths																																			
97110	Therapeutic exercise																																			
97112	Neuromuscular Med.																																			
97504	Orthotic Training																																			
97530	Therapeutic Act.																																			
97116	Gait Training																																			
97542	Wheelchair Training																																			
97703	Orthotic/Pros. Check																																			
97533	Sensory Integration																																			
97601	Selective Debridement																																			
97602	Non-selective Debridemt																																			
	Supervising Therapist Initials																																			
	Therapist Initials																																			
	Total Modalities Rendered																																			
	Minutes of Evaluation																																			
	Minutes of Treatment (am)																																			
	Minutes of Treatment (pm)																																			

= (ea. 15 minutes)

subtotal			
Cumulative Total from Prior Page(s)			
Total for Resident			

Document reason why for the following:

Discharge Codes:

- O = Out-Patient Therapy
- R = Acute Rehab
- D = Deceased
- B = Conld. Under Care-B
- N = Nursing Home With-In
- X = Home
- A = Assisted Living
- E = Nursing Home Elsewhere

HT = Home Health Therapy H = Hospital W = Treatment witheld

Office Manager Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Physical Therapy

Monthly Summary and Recertification

Med A ☐ OTHER DATE:

Patient Last Name:_____ First Name:_____ Provider #: _____

Precautions:_____ Onset Date: _____ SOC Date: Frequency/Duration: _____

Functional Task	Initial Goals	Initial/Start Status	Current Status	Updated/New Goals

Monthly Summary: (Include skilled intervention, provided patient's response to treatment and reason for continuing treatment)

Plan of Treatment

- ☐ Therapeutic Activities
- ☐ Therapeutic Exercise
- ☐ ADL/Self Care
- ☐ Other
- ☐ Neuromuscular
- ☐ Orthotic
- ☐ Wheelchair
- ☐ Group

Signature/Title_____ Date: _____

I certify the need for these services furnished under this plan of treatment and while under my care.

Certification from _____ through _____

Physicians Signature_____Date: _____

☐ Continue Service ☐ DC Service

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Speech Therapy

Introduction

The initial evaluation occurs during the patient's initial encounter with the Therapist. During the evaluation, the therapist spends time collecting information including medical history, detailed prior level of function, current problems or complaints, how this is impacting daily activities or functional limitations. The evaluation process also includes collecting objective information including but not limited to ROM, MMT, pain, sensation, functional assessment (transfers/ambulation/activities of daily living), cognitive status, problem-solving ability, learning potential, communication skills, and swallowing abilities. The assessment involves rating the patient's ability to perform various tasks. Attached links are sample evaluations for Speech Therapy, including rating scales.

Documentation of a visit or encounter, often called a daily note or treatment encounter note, documents the implementation of the Plan of Care established by the therapist. The note should incorporate changes in patient status, a description and progressions of specific interventions used that may be documented in a flow sheet format. Regardless of the format, it is important to convey in the documentation that the interventions provided require the skills, knowledge and judgment of a therapist. Demonstration of skilled care includes documenting the type and level of skilled assistance given to the patient, clinical decision making, and ongoing analysis of patient progress. This can be expressed by recording both the type and amount of manual, visual, and/or verbal cues used by the therapist to assist the patient in completing the exercise/activity completely and correctly. It can also be illustrated by documenting the clinical rationale for selecting the interventions and/or why the interventions are still deemed necessary. Completing a treatment grid is one method of tracking treatments/visits with regard to the specific treatment rendered and time spent on each intervention. Attached links are sample daily notes and treatment grids for Speech Therapy.

Progress notes should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can occur during treatment. The reasons for lack of progress should be noted and the justification for continued treatment be documented if treatment is planned to continue after regression or plateaus. The minimum progress report period shall be at least once every 10 treatment days. In some settings, weekly progress reports are voluntarily prepared to review progress, describe the skilled treatment, and update goals. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary. Harmony Healthcare has always maintained that weekly progress notes provide the optimal means of demonstrating the need for and provision of daily skilled care. The note should incorporate professional judgment regarding the need for continued services. Goals and/or treatment should be modified or upgraded accordingly. Attached links are sample progress notes for Speech Therapy.

Discharge Summary is written at the conclusion of a patient's care. The summary is a synopsis of what occurred from the time of the initial evaluation through the final treatment session. A comparison of the status between the time of the initial encounter with the patient and the final encounter should be present. All skilled interventions/techniques provided during episode of care should be included. Attached links are sample progress discharge summaries for Speech Therapy.

Rating Scale

Rating Scale	I	S	MIN	MOD	MAX	TOTAL
Hearing Sound and speech (w/ or w/o hearing aid)	Normal Some Objective	Hears across repetition; volume	Visual cues; hears at 3-5' rephrasing	Inconsistent, hears at 1'	Inconsistent	Nonfunctional
Comprehension Auditory/Reading (Repetitive)	No cues	Understands basic; occasional rephrasing; more time problem w/complex	Understands basic, 75-90% may require repetition/ rephrasing	Understands basic, 50-74% may require repetition/ rephrasing	Understands basic, 25-49% requires extensive prompting	Comprehends less than 25% of time
Cognitive Status Accurate attention, memory function	No problem	Occasional direction req. memory difficulty	Often direction required in some situations	Frequent direction required in several situations	Consistently needs direction	Total dependence coma, vegetative state, delirium, acute psychotic episode
Problem Solving Reasonable, safe, timely decisions	Independent, appropriate decisions	Standby prompting, cues in stressful or unfamiliar conditions	Solves routine problems 75-90%	Solves routine problems 50-74%	Solves routine problems 25-49%	Total assist, solves problems <25%
Expression Expresses wants & needs	Independent	Expresses needs 90% of time	Expresses needs 75-90% of time. Some cueing	Expresses needs 50-74% of time. Moderate cueing	Expresses needs 25-49% of time requires prompting	Total assist
Communication Alternate/Augmentative Use of alternative communication devices	Independent use	Effective, some obvious difficulties, may require cues	Effectively 75%, occasionally requires cues	Functional 50-74%; cues usually required	Effective 25-49% consistently requires cues	Non-functional more than 25% of tasks
Motor Speech Production (Intelligibility)	Normal	Some altered sound, requires occasional cues	Intelligible 51-75%, requires cues or assistance	Intelligible 26-50%, requires freq cues	Intelligible 0-25% of time, requires prompting	Vocal attempts unintelligible

Key: Level of Independence

I	=	Independent	MOD	=	Moderate Assist (performs 50%-74%)
S	=	Supervision/Set-up (performs 90% or more)	MAX	=	Maximum Assist (performs 25%-49%)
MIN	=	Minimum Assist (performs 75%-89%)	TOTAL	=	Total Assist (performs less than 24%
			N/A	=	Not applicable

Speech Therapy

Narrative Progress Notes

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature

Patient Name _____ Room # _____

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Speech Therapy

Date Time	Prob. No.	All Entries Shall Be Signed With Name and Title

Therapy Notes

_____ Physical Therapy
_____ Occupational
_____ Speech Therapy

Doctor:
File #:
Room #:
Patient:

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Speech Therapy

Progress Flow Sheet

Patient Name: _____ Room #: _____
Diagnosis: _____ Admission Date:_____
ICD-10 Code: _____ Frequency/Duration:_____
Payer Source:_____Expected D/C Date: _____
Med A Med B Medicaid HMO:_____ Primary Therapist: _____

	Date:	Date:	Date:	Date:	Date:	Date:
Swallowing						
Expressive Language						
Receptive Language						
Attention						
Orientation						
Short- Term Memory						
Reasoning						
Problem-Solving						
Sequencing						
Reading						
Writing						
Math						
Current Diet	Regular	Ground	Dysphagia	Puree		
Current Liquids	Thin	Syrup Thick	Honey Thick	Pudding Thick		
Therapists Initials						

Comments:

_____

_____

_____

Therapist's Signature :_____

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Harmony Healthcare INTERNATIONAL

Speech Therapy

Weekly Progress Note

Date: _____

Date							Barriers to Function			
Expressive/Recep Language	**WFL**	**MILD**	**MOD**	**SEV**	**%**	**CUES**		**Improved**	**No Change**	**Declined**
Speech Production							Cognition/safety			
Comprehension							Expressive comm.			
Names Objects							Swallowing			
Communicates Basic Needs							Hearing			
Pragmatics							Comprehension			
Memory/Problem Solving	**WFL**	**MILD**	**MOD**	**SEV**	**%**	**CUES**	Sp. production			
Recall							Voice			
Safety							Attention			
Sequencing							Other:			
Problem Solving							Comments:			
Oral Phase	**TRACE**	**POOR**	**FAIR**	**GOOD**	**CUES**					
Lip Closure							**Skilled Services**			
Food Clearance										
Chewing										
Tongue Function										
Pharyngeal Phase	**TRACE**	**POOR**	**FAIR**	**GOOD**	**CUES**					
Response After Stimulation										
Chin Tuck										
Head Turn										
Voice Quality After Swallow										
Estimated Transit Time										

Functional Improvement

Functional impairment Remaining

Updated Goals ☐ Continue with Goals ☐ _____ Goals Met

Therapist Signature		Date
Patient Name	HICN	Room Number:

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Speech-Language Pathology Therapy Weekly Note

Resident Name: _____ Service Dates: From _____To_____

	DAY:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Functional Tasks	DATE:								GOALS
	Goals								Goal Met Date Met
									Y N
									Y N
									Y N
									Y N
									Y N
Initials									

Signature	Title	Initials

Documented reason in note: E = Evaluation W = Withheld R =Refused

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Speech-Language Pathology Therapy Weekly Note (Continued)

Resident Name: _____ Service Dates: From _____To_____

Weekly Assessment: (Include patient's response to treatment and skilled intervention provided)	
Plan for Revised Goals: (Include reason for continued skilled services)	**Risks/Safety Concerns:** (Functional impairments remained / barriers to achieving goals)
	Anticipated Discharge Date: **Location:**
Signature:	**Date:**

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INSTRUCTIONS FOR COMPLETION OF FORM CMS-700

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000)*.
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider.
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.
7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).
8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAME.
11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*
12. **Plan of Treatment/Functional Goals** - Enter brief current plan of treatment goals for the patient for this billing period. Enter the major short-term goals to reach overall long-term outcome. Enter the major plan of treatment to reach stated goals and outcome. Estimate time-frames to reach goals, when possible.
13. **Signature** - Enter the signature *(or name)* and the professional designation of the professional establishing the plan of treatment.
14. **Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
15. **Physician's Signature** - If the form CMS-700 is used for certification, the physician enters his/her signature. **If certification is required and the form is not being used for certification, check the ON FILE box in item 18.** If the certification is not required for the type service rendered, check the N/A box.
16. **Date** - Enter the date of the physician's signature only if the form is used for certification.
17. **Certification** - Enter the inclusive dates of the certification, **even if the ON FILE box is checked in item 18.** Check the N/A box if certification is not required.
18. **ON FILE** (Means certification signature and date) - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If certification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
19. **Prior Hospitalization** - Enter the inclusive dates of recent hospitalization *(1st to DC day)* **pertinent** to the patient's current plan of treatment. Enter N/A if the hospital stay does not relate to the rehabilitation being rendered.
20. **Initial Assessment** - Enter only **current relevant history** from records or patient interview. Enter the major functional limitations stated, if possible, in objective measurable terms. Include only relevant surgical procedures, prior hospitalization and/or therapy for the same condition. Include only pertinent baseline tests and measurements from which to judge future progress or lack of progress.
21. **Functional Level** (end of billing period) - Enter the pertinent progress made and functional levels obtained at the end of the billing period compared to levels shown on initial assessment. Use objective terminology. Date progress when function can be consistently performed. When only a few visits have been made, enter a note indicating the training/treatment rendered and the patient's response if there is no change in function.
22. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION

(COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME	FIRST NAME M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.

12. PLAN OF TREATMENT FUNCTIONAL GOALS GOALS *(Short Term)* OUTCOME *(Long Term)*	PLAN
13. SIGNATURE *(professional establishing POC including prof. designation)*	14. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*
I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐ N/A 15. PHYSICIAN SIGNATURE — 16. DATE	17. CERTIFICATION FROM THROUGH N/A 18. ON FILE *(Print/type physician's name)* ☐
20. INITIAL ASSESSMENT *(History, medical complications, level of function at start of care. Reason for referral.)*	19. PRIOR HOSPITALIZATION FROM TO N/A

21. FUNCTIONAL LEVEL *(End of billing period)* PROGRESS REPORT ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

	22. SERVICE DATES FROM THROUGH

Form CMS-700-(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-701

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.
2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000)*.
3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.
4. **Provider Name** - Enter the name of the Medicare billing provider.
5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider. *(This is an item which you may enter for your own records.)*
6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.
7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).
8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).
9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.
10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAMPLE.
11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*
12. **Current Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.
13. **Current Plan Update, Functional Goals** - Enter the current plan of treatment goals for the patient for this billing period. *(If the same as shown on the CMS-700 or previous 701 enter "same".)* Enter the short-term goals to reach overall long-term outcome. Justify intensity if appropriate. Estimate time-frames to meet goals, when possible.
14. **Recertification** - Enter the inclusive dates when recertification is required, **even if the ON FILE box is checked in item 17.** Check the N/A box if recertification is not required for the type of service rendered.
15. **Physician's Signature** - If the form CMS-701 is used for recertification, the physician enters his/her signature. If recertification is not required for the type of service rendered, check N/A box. **If the form CMS-701 is not being used for recertification, check the ON FILE box - item 17.** If discharge is ordered, check DC box.
16. **Date** - Enter the date of the physician's signature only if the form is used for recertification.
17. **On File** *(Means certification signature and date)* - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If recertification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**
18. **Reason(s) For Continuing Treatment This Billing Period** - Enter the **major reasons** why the patient needs to continue skilled rehabilitation **for this billing period** (e.g., briefly state the patient's need for specific functional improvement, skilled training, reduction in complication or improvement in safety and how long you believe this will take, if possible or state your reasons for recommending discontinuance). Complete by the rehab specialist prior to physician's recertification.
19. **Signature** - Enter the signature *(or name)* and the professional designation of the individual justifying or recommending need for care *(or discontinuance)* for this billing period.
20. **Date** - Enter the date of the rehabilitation professional's signature.
21. Check the box if services are continuing or discontinuing at end of this billing period.
22. **Functional Level** *(end of billing period)* - Enter the pertinent progress made through the end of this billing period. Use objective terminology. Compare progress made to that shown on the previous CMS-701, item 22, or the CMS-700, items 20 and 21. Date progress when function can be consistently performed or when meaningful functional improvement is made or when significant regression in function occurs. Your intermediary reviews this progress compared to that on the prior CMS-701 or 700 to determine coverage for this billing period. Send a photocopy of the form covering the previous billing period.
23. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of CMS-700 or 701 is required.)

1. PATIENT'S LAST NAME FIRST NAME M.I.		2. PROVIDER NO.	3. HICN
4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
	12. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*		

13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify changes to goals and plan.)*

GOALS *(Short Term)*	PLAN
OUTCOME *(Long Term)*	

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ N/A ☐ DC	14. RECERTIFICATION FROM THROUGH N/A	
15. PHYSICIAN'S SIGNATURE	16. DATE	17. ON FILE *(Print/type physician's name)* ☐

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care.)*

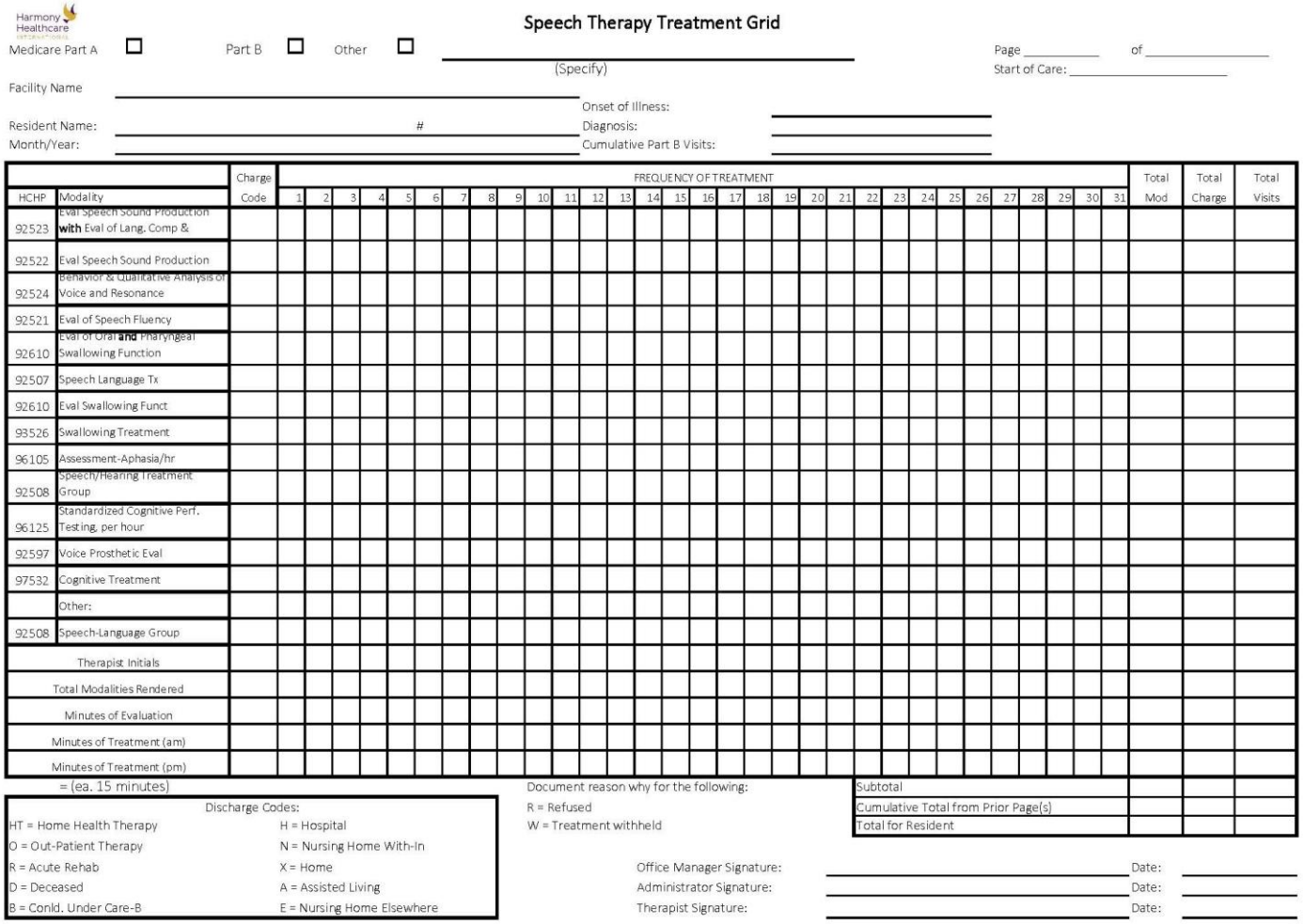
19. SIGNATURE *(or name of professional, including prof. designation)*	20. DATE	21. ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(At end of billing period — Relate your documentation to functional outcomes and list problems still present.)*

22. SERVICE DATES FROM THROUGH

Form CMS-701(11-91)

Speech Therapy



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Speech Therapy Treatment Grid

Medicare Part A ☐ Part B ☐ Other ☐ _____ (Specify)

Page _____ of _____

Start of Care: _____

Facility Name _____

Onset of Illness: _____

Resident Name: _____ # _____ Diagnosis: _____

Month/Year: _____ Cumulative Part B Visits: _____

HCHP	Modality	Charge Code	FREQUENCY OF TREATMENT 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Mod	Total Charge	Total Visits
92523	Eval Speech Sound Production **with** Eval of Lang. Comp &																																			
92522	Eval Speech Sound Production																																			
92524	Behavior & Qualitative Analysis of Voice and Resonance																																			
92521	Eval of Speech Fluency																																			
92610	Eval of Oral **and** Pharyngeal Swallowing Function																																			
92507	Speech Language Tx																																			
92610	Eval Swallowing Funct																																			
93526	Swallowing Treatment																																			
96105	Assessment-Aphasia/hr																																			
92508	Speech/Hearing Treatment Group																																			
96125	Standardized Cognitive Perf. Testing, per hour																																			
92597	Voice Prosthetic Eval																																			
97532	Cognitive Treatment																																			
	Other:																																			
92508	Speech-Language Group																																			
	Therapist Initials																																			
	Total Modalities Rendered																																			
	Minutes of Evaluation																																			
	Minutes of Treatment (am)																																			
	Minutes of Treatment (pm)																																			

= (ea. 15 minutes)

Discharge Codes:	
HT = Home Health Therapy	H = Hospital
O = Out-Patient Therapy	N = Nursing Home With-In
R = Acute Rehab	X = Home
D = Deceased	A = Assisted Living
B = Contd. Under Care-B	E = Nursing Home Elsewhere

Document reason why for the following:
R = Refused
W = Treatment withheld

Subtotal		
Cumulative Total from Prior Page(s)		
Total for Resident		

Office Manager Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Speech-Language Pathology Monthly Summary and Recertification

MED A ☐ Other Date:

Patient Last Name: _____ First Name:_____ Provider #: _____

Precautions:_____ Onset Date: _____ SOC Date: _____ Frequency/Duration: _____

Functional Task	Initial Goals	Initial/Start Status	Current Status	Updated/New Goals

Monthly Summary: (include skilled intervention, provided patient's response to treatment and reason for continuing treatment)	Plan of treatment
	☐ Speech Language Treatment ☐ Dysphagia Treatment ☐ Group ☐ Other

Signature/Title_____ Date: _____ Certification From _____ Through _____

I certify the need for these services furnished under this plan of treatment and while under my care.

Physicians Signature_____Date: _____ ☐ Continue Service ☐ DC Service

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Rehabilitation RUG Classification

SNF Prospective Payment System

General Provisions

Section 4432 of the Balanced Budget Act (BBA) of 1997 established provisions for a Prospective Payment System (PPS) for Skilled Nursing Facilities (SNF) under Section 1888(e) of the Social Security Act (the Act) effective with cost reporting periods beginning on or after July 1, 1998. Under these provisions, covered Medicare Part A SNF services are no longer paid based on reasonable cost or through low volume prospectively determined rates, but rather through case-mix adjusted per-diem prospective payment rates for all SNFs. The payment rates (i.e., full Federal rate or transition rate) represent payment in full subject to applicable coinsurance for all costs (routine, ancillary, and capital-related) associated with furnishing covered SNF services to Medicare beneficiaries other than costs associated with operating approved educational activities.

Covered SNF Services

Covered SNF services include post hospital SNF services for which benefits are provided under Medicare Part A and all items and services for which prior to July 1, 1998, payment has been made under Medicare Part B other than the following services furnished to SNF residents during a Medicare Part A stay, regardless of source:

- Physician's services;
- Physician assistant services;
- Nurse practitioner services;
- Clinical nurse specialist services;
- Certified mid-wife services;
- Qualified psychologist services;
- Certified registered nurse anesthetist services;
- Certain dialysis related services and Erythropoietin (EPO) for certain dialysis patients;
- Hospice care related to a terminal condition;
- Ambulance trips that transport the beneficiary to the SNF for admission or from the SNF following discharge; and,
- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services furnished to SNF residents during a Medicare Part A covered stay.

Consolidated Billing Requirements Under Part A

Consolidated billing applies to services and supplies that a SNF resident receives while in a SNF PPS Medicare Part A stay.

A beneficiary's status as a SNF resident ends when the beneficiary receives outpatient services from a Medicare participating hospital or Critical Access Hospital (CAH); but only with respect to those services that are not furnished pursuant to the SNF's required resident assessment or comprehensive care plan. The purpose of citing the SNF care plan in the context of an outpatient hospital visit is to clarify that the SNF retains the overall billing responsibility for essentially the entire package of care furnished during the outpatient visit, other than certain specifically excluded services.

Beneficiaries in a Part A Covered Stay

SNFs are required to consolidate billing to their intermediary for their covered Medicare inpatient services. However, certain services that are rendered to SNF inpatients are excluded from the SNF Prospective Payment System (PPS) reimbursement and are also excluded from consolidated billing by the SNF. Those services must be billed to Medicare Part B by the rendering provider and not by the SNF (except screening and preventive services as described in the next paragraph.) A list of services excluded from consolidated billing is found in the Medicare Claims Processing Manual, Chapter 6, "SNF Inpatient Part A Billing," §§20-20.4.

Screening and preventive services are not included in the SNF PPS amount but may be paid separately under Medicare Part B for Part A patients who also have Part B coverage. Screening and preventive services are covered only under Medicare Part B. Only the SNF may bill for screening and preventive services under Medicare Part B for its covered Medicare Part A inpatients. Bill type 22X is used for beneficiaries in a covered Medicare Part A stay and for beneficiaries that are Medicare Part B residents. TOB 23x is used for SNF outpatients or for beneficiaries not in the SNF or DPU. The SNF must provide the service or obtain it under arrangements.

Coverage, billing and payment guidelines are found in the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services," Chapter 17, "Drugs and Biologicals;" and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.

There are certain medical and other health services for which payment may not be made to a SNF. Most of these are professional services performed by physicians and other practitioners. These services are always billed to the Medicare Part B Carrier. Others are services that have been determined to require a hospital setting to assure beneficiary safety. FI or MAC shared systems receive an annual file listing these non-payment HCPCS in November, and, if necessary,

a quarterly update via a onetime only notification. Physicians, non-physician practitioners, and suppliers billing the carrier, and providers billing the FI or MAC should consult the CMS Website at http://www.cms.hhs.gov/SNFConsolidatedBilling/ for the lists of separately billable services.

Excluded Services from Consolidated Billing

In the outpatient hospital context, this exclusion applies to a number of exceptionally intensive and cost services that lie well beyond the scope of the care that SNFs would ordinarily furnish and, thus, beyond the scope of the care plan itself, as well as emergency services (which, by their nature, cannot be anticipated and planned for in advance).

Outpatient hospital emergency services are defined in 42 CFR, Section 424.101, as services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require the use of the most accessible hospital available and equipped to furnish those services.

This exclusion is not invoked merely because a particular outpatient hospital service does not appear in the individual SNF care plan of the person receiving the service. Rather, the exclusion applies only to those specified categories of service that, by definition, lie well beyond the scope of SNF care plans generally.

In addition to the previously mentioned excluded services, the following services are also excluded from consolidated billing under Medicare Part A:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging (MRI);
- Ambulatory surgery involving the use of an operating room;
- Emergency services;
- Radiation therapy;
- Angiography codes;
- Lymphatic procedures; and
- Venous procedures.

See HCPCS list at end of Section VI.

Services Beyond the Scope of the Medicare Part A SNF Benefit

The following services are beyond the scope of the SNF Medicare Part A benefit and are excluded from payment under Medicare Part A SNF PPS and from the requirement for consolidated billing. These services must be paid to the practitioner or provider that renders them and are billed separately by the rendering provider/supplier/practitioner to the MAC or FI. The SNF may not bill excluded services separately under Medicare Part B for its inpatients entitled to Medicare Part A benefits. HCPCS procedure codes representing these excepted services for services billed to the Carriers, FIs or MACs are updated as frequently as quarterly on the CMS Website at: http://www.cms.hhs.gov/SNFConsolidatedBilling/ Physicians, non-physician practitioners, and suppliers billing the carrier should consult the above link for lists of separately billable services.

Note: There are separate Annual Update files for services billed to Carriers and billed to FIs posted to the website mentioned above. CMS Pub 100-4 Medicare Claims Processing Trans 846.

SNF Coverage Guidelines

Coverage determinations (i.e., level of care determinations) are significantly simplified by adopting the system for classifying residents based on resource utilization known as Resource Utilization Group, Version IV (RUG-IV). SNFs utilize information from the Minimum Data Set (MDS) Version 3.0, Resident Assessment Instrument (RAI), to classify residents into the RUG-IV groups.

Resident Assessment Instrument (RAI)

The Long-Term Care Resident Assessment Instrument (RAI) is a three component document consisting of the following:

- Minimum Data Set (MDS);
- Care Area Assessments (CAAs) and Triggers; and
- Utilization Guidelines.

Questions and answers regarding the Long-Term Care Resident Assessment Instrument are available on the Health Care Financing Administration's (HCFA) web site at:

www.hcfa.gov/medicare/hsqb/mds20/res_man.htm

Minimum Data Set (MDS)

The Minimum Data Set (MDS), Version 3.0 contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the basis of a comprehensive assessment. The assessments are required by law and are to be performed based on a predetermined schedule for purposes of Medicare reimbursement. The MDS consists of the following types of assessments:

- Comprehensive Assessment (MDS plus CAAs)
- Non-Comprehensive Assessments
- PPS Scheduled Assessments
- OMRA Assessments
- Discharge Assessments
- Entry Tracking Forms
- Death in Facility Tracking Form

The software programs used by SNFs to assign patients to appropriate RUG-IV groups based on the MDS 3.0, called Groupers, are available from many software vendors or by accessing the HCFA web site at:

www.hcfa.gov/medicare/hsqb/mds20

Triggers

The triggers are specific resident responses for one or a combination of MDS data elements. The triggers identify residents who may either have or be at risk for developing specific functional problems and require further evaluation using the CAAs.

Care Area Assessments (CAAs)

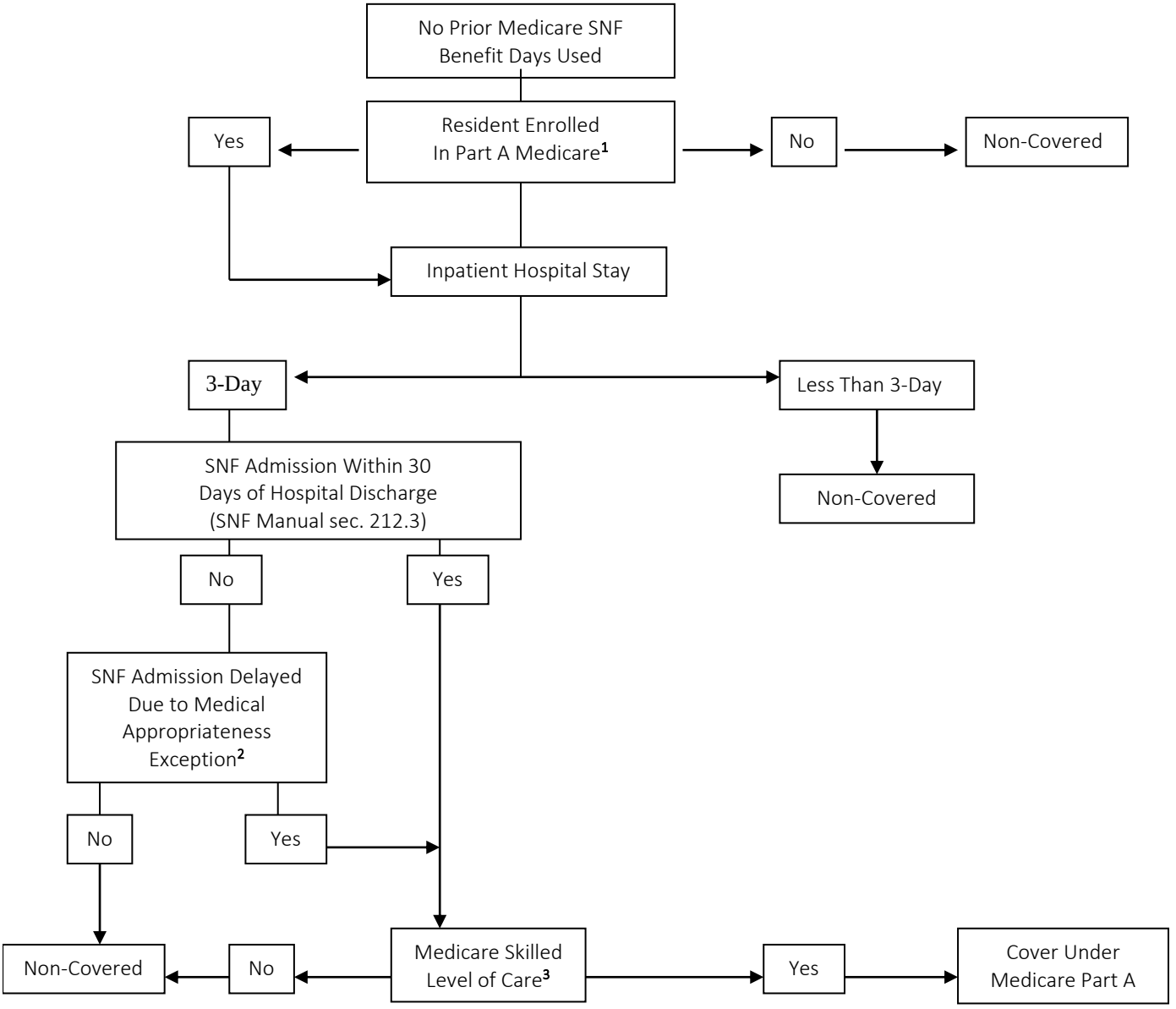
The MDS alone does not provide a comprehensive assessment. The MDS is used for preliminary screening, to identify actual or potential resident problems, strengths and preferences. In addition, the Care Area Assessments provide a framework of problem oriented indicators based on problem identifiers or trigger conditions functioning to facilitate the decision-making process and provide a sound basis for the resident care plan.

The following are 20 such identifiers:

- Delirium;
- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of Daily Living (ADL) Function/Rehabilitation Potential;
- Urinary Incontinence and Indwelling Catheter;

- Psychosocial Well-Being;
- Mood State;
- Behavior Symptoms;
- Activities;
- Falls;
- Nutritional Status;
- Feeding Tube;
- Dehydration/Fluid Maintenance;
- Dental Care;
- Pressure Ulcer;
- Psychotropic Drug Use;
- Physical Restraints,
- Pain; and,
- Return to Community Referral

Medicare Benefit Period Decision Tree



Resource Utilization Group

Resource Utilization Group (RUG), Version IV

The RUG-IV system replaced the RUG-III for Medicare starting on October 1, 2010. For Medicare billing purposes, there is a payment code associated with each of the 66 RUG-IV groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule. Facilities must send each beneficiary's MDS assessment to the State and claims for Medicare payment to the fiscal intermediary (FI) or MAC on a 30-day cycle.

The RUG-IV Classification system utilizes patient characteristics and health status information, e.g., diagnosis, ADL performance ability and treatment received, and places the resident into a resource utilization group for payment purposes.

The RUG-IV classification represents the following:

- Eight major categories representing the first level of classification;
- The categories, except for extensive services are then subdivided into 63 groups based on ADL scores, nursing rehabilitation and signs of depression, taken from MDS data elements; and,
- Arranged in hierarchical order (highest utilization in the top group) based upon amount and type of service or resource utilized.

Beneficiaries that are classified to any of the highest 52 of the 66 RUG-IV groups are considered to meet the SNF level of care definition found in the Medicare Intermediary Manual (MIM). The RUG classification system allows for an expedited determination that a beneficiary in one of the upper 52 groups meets the SNF level of care requirements, and for assignment to an appropriate payment category. However, it does not supersede any coverage requirements related to a specific service, or the overall requirement that the services provided to the beneficiary be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Health Insurance PPS (HIPPS) Code Defined

The Health Insurance PPS (HIPPS) rate code consists of the RUG-IV code, which is obtained from the Grouper software program and a two-digit assessment indicator (Attachment M HIPPS Modifiers). SNFs must use the version of the Grouper software program identified by HCFA for national PPS as described in the Federal Register for that year. The Grouper translates the MDS data into a case mix-group and assigns the correct RUG-IV code. The assessment indicators were derived by HCFA using the codes in the current version of the RAI.

Both components of the HIPPS rate code must be present on a claim or the claim will be rejected. The grouper will not automatically assign the two-digit indicator. The assessment indicator must be assigned manually, unless the software used by the provider has been updated to include this feature.

The HIPPS rate code that appears on the HCFA 1450 UB04 claim form must match the locked assessment. The SNF cannot put a HIPPS rate code on the HCFA 1450 UB04 claim form that does not match the locked assessment. The first three digits of item T3 (Medicare case-mix) in the current version of the MDS and the first three digits of the HIPPS rate code on the HCFA 1450 UB04 claim form must be identical. The last two digits of item T3 in the current version of the MDS will be "07" while the last two digits of the HIPPS rate code on the HCFA 1450 UB04 claim form will be the two-digit assessment indicator which describes the reason for the assessment. A SNF cannot bill for a covered day until that day has actually been used and an assessment has been transmitted for those billable days.

Rehabilitation RUG Classification

Classification Grid
Medicare Part A
RUG-IV 66 Grouper

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Rehabilitation / Extensive Services				
Ultra High RUX RUL		**11-16** **2-10**	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • Rx 720 minutes/week minimum and • At least 1 discipline 5 days/week and • A second discipline at least 3 days/week and • **Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident** **and** • **ADL score > =2** • **See updated Extensive Services Category***	O, A,B,C, 1,2,3,4
Very High RVX RVL		**11-16** **2-10**	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • Rx 500 minutes/week minimum and • One discipline at least 5 days/week and • **Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident** **and** • **ADL score > =2** • **See updated Extensive Services Category**	O, A,B,C, 1,2,3,4
High RHX RHL		**11-16** **2-10**	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • Rx 325 minutes/week minimum and • One discipline 5 days/week and • **Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident** **and** • **ADL score > =2** • **See updated Extensive Services Category***	O, A,B,C, 1,2,3,4

Classification Grid

Rehabilitation RUG Classification

Medicare Part A
RUG-IV 66 Grouper

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Rehabilitation / Extensive Services (Continued)				
Medium RMX RML		**11-16** **2-10**	Residents needing both extensive medical services and PT, OT or SLP services. • Rx 150 minutes/week minimum AND • 5 distinct calendar days of therapy across disciplines AND • **Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND** • **ADL score> =2** • **See updated Extensive Services Category***	O, A,B,C, 1,2,3,4
Low RLX		**2-16**	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. AND • 3 distinct calendar days of therapy across disciplines AND • Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services) AND • **Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident** **AND** • **ADL score > =2** • **See updated Extensive Services Category***	O, A,B,C, 1,2,3,4

***Updated Extensive Services:**

Extensive Services qualification based on ADL Sum > 2 and one of the following services:

- **Tracheostomy Care**
- **Ventilator / Respirator OR**
- **Isolation for active infectious disease while a resident**

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Rehabilitation RUG Classification

Classification Grid
Medicare Part A
RUG-IV 66 Grouper

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Rehabilitation				
Ultra High RUC RUB RUA		**11-16** **6-10** **0-5**	In last 7 days: • Received 720 minutes/week minimum and • At least 1 discipline 5 days/week and • 2nd for at least 3 days/week	O, A,B,C, 1,2,3,4
Very High RVC RVB RVA		**11-16** **6-10** **0-5**	In last 7 days: • Received 500 minutes/week minimum and • At least 1 discipline 5 days/week	O, A,B,C, 1,2,3,4
High RHC RHB RHA		**11-16** **6-10** **0-5**	In last 7 days: • Received 325 minutes/week minimum and • At least 1 discipline -5 days/week	O, A,B,C, 1,2,3,4
Medium RMC RMB RMA		**11-16** **6-10** **0-5**	In last 7 days: • Received 150 minutes/week minimum and • 5 distinct calendar days of therapy across disciplines	O, A,B,C, 1,2,3,4
Low RLB RLA		**11-16** **0-10**	In last 7 days: • Received 45 minutes/week minimum and • 3 distinct calendar days of therapy across disciplines and • Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services)	O, A,B,C, 1,2,3,4

Rehabilitation RUG Classification

Classification Grid
Medicare Part A
RUG-IV 66 Grouper

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Extensive Services				
ES3		2-16	Residents receiving the following complex clinical care: • **Tracheostomy Care** **or** • **Ventilator / Respirator** **or** • **Isolation for active infectious disease while a resident** **and** • **ADL score >=2** Notes: Qualifiers count for end splits • Tracheostomy care (while a resident) and • Ventilator / Respirator (while a resident)	O0100E2 O0100F2 O0100M2 O0100E2 O0100F2
ES2		2-16	• Tracheostomy care (while a resident) or • Ventilator / Respirator (while a resident)	O0100E2 O0100E2
ES1		2-16	• Isolation for active infectious disease (while a resident)	O0100M2
RUG Level		**ADL Score**	**Requirements**	**MDS 3.0 Section**
Special Care High				
HE2 HE1	Yes No	15-16 15-16	Residents receiving the following complex clinical care or with a following medical condition: • **Comatose and completely ADL dependent** • **Septicemia** • **Diabetes with daily injections requiring physician order changes on 2 or more days**	B, B0100 I, I2100
HD2 HD1	Yes No	11-14 11-14	• Quadriplegia and ADL score > = 5 • **Chronic obstructive pulmonary disease and shortness of breath when lying flat**	I, I2900; Section N, N0350,A I, I5100
HC2 HC1	Yes No	6-10 6-10	• Fever with ○ Pneumonia ○ Vomiting ○ **Feeding tube:** 26-50% or more calories and at least 501 cc of fluid **or** 51% of the calories for the entire 7 days ○ Weight loss	I, I6200 J, J1550,A I, I2000 J, J1550,B K, K0500,B K, K0300
HB2 HB1	Yes No	2-5 2-5	• **Parenteral/IV feedings** • Respiratory therapy for 7 days and • **ADL score > =2** Notes: Signs of depression used for end splits; PHQ score =>10	K, K0500,A O, O0400,D

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Rehabilitation RUG Classification

Medicare Part A
RUG-IV 66 Grouper

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Special Care Low				
LE2 LE1	Yes No	**15-16** **15-16**	Residents receiving the following complex clinical care or with a following medical condition: • Cerebral palsy and ADL score >=5 • Multiple sclerosis and ADL score >=5 • **Parkinson's disease and ADL score >=5**	I, I4400 I, I5200
LD2 LD1	Yes No	**11-14** **11-14**	• **Feeding tube** 26-50% or more calories and at least 501 cc of fluid **or** 51% of the calories for the entire 7 days • Ulcers with 2 or more skin treatments ○ 2 or more stage II ○ 1 or more stage III or IV pressure ulcers ○ **Unstageable secondary to slough/eschar** ▪ **2 or more venous/arterial ulcers OR** ▪ **1 stage II pressure ulcer AND** ▪ **1 venous/arterial ulcer**	I, I5300 K, K0700,A,B, M M, M0800,A M, M0800,B,C M, M1030 M, M-0800,A M, M1030 M, M1040,A,C
LC2 LC1	Yes No	**6-10** **6-10**		
LB2 LB1	Yes No	**2-5** **2-5**	• Foot infection, diabetic foot ulcer or open lesions on the foot with treatment • Radiation therapy while a resident • **Respiratory failure and oxygen therapy while a resident** • **Dialysis while a resident** and • ADL score >=2 Notes: Signs of depression used for end splits; PHQ score =>10	O, O0100,B,2 I, I6300 O,O0100C O, O0100,J,2

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Rehabilitation RUG Classification

Classification Grid
Medicare Part A
RUG-IV 66 Grouper

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Clinically Complex				
CE2 CE1	Yes No	15-16 15-16	Residents with Extensive Services, Special Care High or Special Care Low qualifier. and • ADL score = 0-1 or Residents with any one of the following clinically complex qualifiers:	
CD2 CD1	Yes No	11-14 11-14	• Pneumonia • Hemiplegia and ADL score >=5	I, I2000 I, I4900
CC2 CC1	Yes No	6-10 6-10	• Surgical wounds or open lesions with treatment • Burns	M, M1040,E
			• Chemotherapy while a resident	M, M1040,F
CB2 CB1	Yes No	2-5 2-5	• Oxygen while a resident • IV medications while a resident • Transfusions while a resident	O, O0100,A,2 O, O0100,C,2 O, O0100,H,2 O, O0100,I,2
CA2 CA1	Yes No	0-1 0-1	Notes: Signs of depression used for end splits: PHQ score =>10	
Rehabilitation / Extensive Services				
BB2	*	2-5	Residents having cognitive impairment BIMS score<=9 or CPS >=3 or	C
BB1	**	2-5	• Hallucinations or delusions or	E0100A E0100B
BA2	*	0-1	Residents displaying any of the following on 4 or more days over last 7 days:	
BA1	**	0-1	• Physical or verbal behavioral symptoms toward others • Other behavioral symptoms • Rejection of care • Wandering	E, E0200,A,B,C E, E0300,1
	* 2 or more Restorative Services 6+ days ** Less Restorative Nursing		and • ADL score <=5 Notes: Restorative nursing used for end splits. See Reduced Physical Function for restorative nursing services count	E, E0900

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Classification Grid
Medicare Part A
RUG-IV 66 Grouper

RUG Level	Restorative Nursing	ADL Score	Requirements	MDS 3.0 Section
Reduced Physical Functioning				
PE2 PE1	* **	15-16 15-16	Residents whose needs are primarily for activities of daily living and general supervision. • Residents not qualifying for other categories • Restorative nursing services: ○ Urinary and/or bowel training program ▪ Passive and/or active ROM ○ Amputation/prosthesis care training ▪ Splint or brace assistance ▪ Dressing or grooming training ▪ Eating or swallowing training ▪ Transfer training ▪ Bed mobility and/or walking training ▪ Communication training	O, 0500,A-J H, H0200/H0500
PD2 PD1	* **	11-14 11-14		
PC2 PC1	* **	6-10 6-10		
PB2 PB1	* **	2-5 2-5		
PA2 PA1	* **	0-1 0-1		
	*2 or more Restorative Services 6+ days **Less Restorative Nursing		Notes: No clinical variables used	

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RUG-IV 66-Group Model Calculation Worksheet for SNFs

The purpose of this RUG-IV Version 1.00 calculation worksheet for the 66-group model is to provide a step-by-step walk-through to manually determine the appropriate RUG-IV Classification based on the data from an MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to ensure that it represents the standard logic.

In the RUG-IV 66-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups, representing 10 different levels of rehabilitation services. In the 66-group model, the residents in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while residents in the Rehabilitation groups have the next highest level of need. Therefore, the 66-group model has the Rehabilitation Plus Extensive Services groups first followed by the Rehabilitation groups, the Extensive Services groups, the Special Care High groups, the Special Care Low groups, the Clinically Complex groups, the Behavioral Symptoms and Cognitive Performance groups, and the Reduced Physical Function groups.

There are two basic approaches to RUG-IV Classification:

- Hierarchical classification and
- Index maximizing classification.

The current worksheet was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are included below (see “Index Maximizing Classification”). Note that the RUG classification used for Medicare PPS Part A billing is based on the index maximizing approach.

Hierarchical Classification: The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the RUG-IV model; the assigned classification is the first group for which the resident qualifies. In other words, start with the Rehabilitation Plus Extensive Services groups at the top of the RUG-IV model. Then go down through the groups in hierarchical order: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 66 individual RUG-IV groups for which the resident qualifies, assign that group as the RUG-IV classification.

If the resident qualifies in the Extensive Services group and a Special Care High group, always choose the Extensive Services classification because it is higher in the hierarchy. Likewise, if the

resident qualifies for Special Care Low and Clinically Complex, always choose Special Care Low. In hierarchical classification, always pick the group nearest the top of the model.

Index Maximizing Classification: Index maximizing classification is used in Medicare PPS (and most Medicaid payment systems) to select the RUG-IV group for payment. There is a designated Case Mix Index (CMI) that represents the relative resource utilization for each RUG-IV group. For index maximizing, first determine all of the RUG-IV groups for which the resident qualifies. Then, from the qualifying groups, choose the RUG-IV group that has the highest CMI. For Medicare PPS, the index maximizing method uses the CMIs effective for the appropriate Federal Fiscal Year.

While the following worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. For index maximizing, evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, again start at the beginning of the worksheet. Then work down through all of the 66 RUG-IV Classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When finished, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index-maximized classification for the resident.

Non-Therapy Classification: In some instances, the SNF provider may be required to report, on the SNF Medicare claim, a non-therapy RUG-IV classification according to the SNF PPS policies (as noted elsewhere in this chapter, Chapter 8 of the **Medicare Benefit Policy Manual**, and Chapter 6 of the **Medicare Claims Processing Manual**). The non-therapy classification uses all the RUG-IV payment items except the rehabilitation therapy Items (O0400A, B, C) to determine a non-therapy, clinical RUG. To obtain a non-therapy RUG with this worksheet, skip Category I (Rehabilitation Plus Extensive Services) and Category II (Rehabilitation) and start with Category III (Extensive Services). Both the standard Medicare Part A RUG reported in Item Z0100A and the Medicare Part A non-therapy RUG in Item Z0150A are recorded on the MDS 3.0. When rehabilitation services are not provided, the standard Medicare Part A RUG will match the Medicare Part A non-therapy RUG.

Rehabilitation RUG Classification

Calculation of Total "ADL" Score
RUG-IV, 66-Group Hierarchical Classification

The ADL score is a component of the calculation for placement in all RUG-IV groups. The ADL score is based upon the four "late loss" ADLs (bed mobility, transfer, toilet use, and eating), and this score indicates the level of functional assistance or support required by the resident. It is a very important component of the classification process.

Step # 1

To calculate the ADL score use the following chart for bed mobility (G0110A), transfer (G0110B), and toilet use (G0110I). **Enter the ADL score for each item.**

Self-Performance Column 1 =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 7, or 8	and	(any number)	0	G0110A = ___
2	and	(any number)	1	G0110B = ___
3	and	-, 0, 1, or 2	2	G0110I = ___
4	and	-, 0, 1, or 2	3	
3 or 4	and	3	4	

Step # 2

To calculate the ADL score for eating (G0110H), use the following chart. Enter ADL score.

Self-Performance Column 1 (G0110H) =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 2, 7, or 8	and	-, 0, 1, or 8	0	G0110H = __
-, 0, 1, 2, 7, or 8	and	2 or 3	2	
3 or 4	and	-, 0, or 1	2	
3	and	2 or 3	3	
4	and	2 or 3	4	

Step # 3

Add the four scores for the total ADL score. This is the **RUG-IV Total ADL Score.** The total ADL score ranges from 0 through 16.

Total RUG-IV ADL Score _____

Other ADLs are also very important, but the research indicates that the late loss ADLs predict resource use most accurately. The early loss ADLs do not significantly change the classification hierarchy or add to the prediction of resource use.

Calculation of Total Rehabilitation Therapy Minutes
RUG-IV, 66- Group Hierarchical Classification

For Speech-Language Pathology Services (Items at O0400A), Occupational Therapy (Items at O0400B), and Physical Therapy (Items at O0400C), the MDS 3.0 separately captures minutes that the resident was receiving individual, concurrent, and group therapy (see Chapter 3, Section O for definitions) during the last 7 days. For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy. The total minutes used for RUG-IV classification include all minutes in individual therapy, one-half of the minutes in concurrent therapy, and all minutes in group therapy for non-Medicare classification. For Medicare Part A classification, the total minutes used for RUG-IV classification include all minutes in individual therapy, one-half the minutes in concurrent therapy, and the group time is allocated among 4 residents and only one-fourth of the minutes of group time are included for the resident in the total minutes for RUG-IV classification. For Medicare Part A there is a limitation that the group minutes cannot exceed 25% of the total minutes, a limitation that is applied by the grouper software. This limitation is applied after allocation of group minutes.

Skip this section if therapy is not provided.

In Steps #1 through #3 in calculating Rehabilitation Therapy Minutes, retain all decimal places in the calculated values. Values where decimal points are retained are indicated by an asterisk (*).

Step # 1

Calculate the total minutes for speech-language pathology services as follows:

Add the individual minutes (O0400A1) and one-half of the concurrent minutes (O0400A2). Add all of the group minutes (O0400A3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:
If allocated group minutes (one-quarter of O0400A3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400A1) and one-half of concurrent minutes (O0400A2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:
Speech-Language Pathology Services Minutes* = _____

Step # 2

Calculate the total minutes for occupational therapy as follows:

Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). Add all of the group minutes (O0400B3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400B3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Occupational Therapy Minutes* = _____

Step # 3

Calculate the total minutes for physical therapy as follows:

Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). Add all of the group minutes (O0400C3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400C3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Physical Therapy Minutes* = _____

Step # 4

Sum the speech-language pathology services minutes, occupational therapy minutes, and physical therapy minutes and record as Total Therapy Minutes. These are the minutes that will be used for RUG-IV rehabilitation therapy classification (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used).

Total Therapy Minutes^ = _____

Total Therapy Minutes is not rounded. Record only the whole number with all values after the decimal dropped.

Total Rehabilitation Therapy Minutes Calculation Example

Mrs. D., whose stay is covered under SNF PPS, received the following rehabilitation services during FY2012 (group therapy time is allocated) as follows:

Speech-language Pathology Services:

Individual minutes = 110 (Item O0400A1),
Concurrent minutes = 99 (Item O0400A2),
Group minutes = 100 (Item O0400A3).
Calculate total SLP minutes = 110 + 99/2 + 100/4 = 184.5 (retain the decimal).
Check group proportion (after group allocation) = (100/4)/184.5 = 0.136.
Do not adjust SLP minutes for Medicare Part A since group proportion is not greater than .25. Use unadjusted total SLP minutes.

Total Speech-Language Pathology Services Minutes = **184.5** (retain the decimal).

Occupational Therapy:

Individual minutes = 78 (Item O0400B1),
Concurrent minutes = 79 (Item O0400B2),
Group minutes = 320 (Item O0400B3).
Calculate total OT minutes = 78 + 79/2 + 320/4 = 197.5 (retain the decimal).
Check group proportion = (320/4)/197.5 = 0.405.
Adjust OT minutes for Medicare Part A since group proportion is greater than .25.
Adjusted Occupational Therapy Minutes = [(78 + 79/2) x 4]/3 = **156.6666** (retain the decimal).

Physical Therapy:

Individual minutes = 92 (Item O0400C1),
Concurrent minutes = 93 (Item O0400C2),

Group minutes = 376 (Item O0400C3).
Calculate total PT minutes = 92 + 93/2 + 376/4 = 232.5 (retain the decimal).
Check group proportion = (376/4)/232.5 = 0.404.
Adjust PT minutes for Medicare Part A since group proportion is greater than .25.

Adjusted Physical Therapy Minutes = [(92 + 93/2) x 4]/3 = **184.6666** (retain the decimal).

Total Adjusted Therapy Minutes:

Sum SLP, OT and PT minutes after any adjustment= 184.5 + 156.6666 + 184.6666 = 525.8332
Drop decimals = **525 minutes**
(This is the total therapy minutes value for RUG-IV classification).

Medicare Short Stay Assessment
RUG-IV, 66-Group Hierarchical Classification

Step # 1

Set the Medicare Short Stay Indicator (Z0100C) as follows:

RUG-IV uses an alternative rehabilitation therapy classification when an assessment is a Medicare Short Stay assessment. To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (Item A0310C = 1).** This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but should not be combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.

2. **A PPS 5-day (Item A0310B = 01) or readmission/return assessment (A0310B = 06) has been performed.** The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.

3. **The ARD (Item A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare covered stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.

4. **The ARD (Item A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.

5. **The ARD (Item A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Items O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short Stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.

6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A stay (including weekends).** The end of Medicare stay date (Item A2400C) minus the earliest start date for the three therapy disciplines (Items O0400A5, O0400B5, or O0400C5) must be 3 days or less.

7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (Items O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (Item A2400C). Therapy is considered to be ongoing when:
    - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
    - The resident's SNF benefit exhausted and therapy continued to be provided, or
    - The resident's payer source changed and therapy continued to be provided.

8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Item Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

If all eight conditions are satisfied, record "Yes" in the Medicare Short Stay Assessment Indicator Z0100C); otherwise record "No."

Medicare Short Stay Assessment Indicator Yes_____ No_____

Step # 2

If the Medicare Short Stay Assessment Indicator is "Yes," then calculate the Medicare Short Stay Average Therapy Minutes as follows:

This average is the Total Therapy Minutes (calculated above in Calculation of Total Rehabilitation Therapy Minutes) divided by the number of days from the start of therapy (earliest date in O0400A5, O0400B5, and O0400C5) through the assessment reference date (A2300). For example, if therapy started on August 1 and the assessment reference date is August 3, the average minutes is calculated by dividing by 3 days. Discard all numbers after the decimal point and record the result.

Medicare Short Stay Average Therapy Minutes = _____

See Section 6.4 of the RAI Manual for the Medicare Short Stay Assessment Algorithm.

Category I: Rehabilitation Plus Extensive Services

RUG-IV, 66-Group Hierarchical Classification

Start the classification process beginning with the Rehabilitation Plus Extensive Services category. In order for a resident to qualify for this category, he/she must meet three requirements: (1) have an ADL score of 2 or more, (2) meet one of the criteria for the Extensive Services category, and (3) meet the criteria for one of the Rehabilitation categories.

Step # 1

Check the resident's ADL score. If the resident's ADL score is 2 or higher, go to Step #2.
If the ADL score is less than 2, skip to Category II now.

Step # 2

Determine whether the resident is coded for one of the following treatments or services:
O0100E2 Tracheostomy care while a resident O0100F2 Ventilator or respirator while a resident O0100M2 Infection isolation while a resident
If the resident does not receive one of these treatments or services, skip to Category II now.

Step #3

Determine if the resident's rehabilitation therapy services (speech-language pathology services, or occupational or physical therapy) satisfy the criteria for one of the RUG-IV Rehabilitation categories. If the resident does not meet all of the criteria for a Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).

- Ultra High Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)
    1. In the past 7 days:
        Total Therapy Minutes (calculated on page 6-25 – 6-28) of 720 minutes or more
        and
        One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
        and
        A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days
    2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":
        Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more

Rehabilitation RUG Classification

RUG IV ADL Score	RUG-IV Class
11-16	RUX
2-10	RUL

• **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more

and

At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RVX
2-10	RVL

• **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more

and

At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RHX
2-10	RHL

• **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more

and

At least 5 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Rehabilitation RUG Classification

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RMX
2-10	RML

• **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more

and

At least 3 days of any combination of the 3 disciplines (O0400A4, plus O0400B4 plus O0400C4)

and

Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes.

*Restorative Nursing Services

H0200C, H0500** Urinary toileting program and/or bowel toileting program
O0500A,B** Passive and/or active ROM
O0500C Splint or brace assistance
O0500D,F** Bed mobility and/or walking training
O0500E Transfer training
O0500G Dressing and/or grooming training
O0500H Eating and/or swallowing training
O0500I Amputation/prostheses care
O0500J Communication training

**Count as one service even if both provided.

RUG-IV ADL Score	RUG-IV Class
2-16	RLX

RUG-IV Classification_____

If the resident does not classify in the Rehabilitation Plus Extensive Services Category, proceed to Category II.

Category II: Rehabilitation
RUG-IV, 66-Group Hierarchical Classification

Rehabilitation therapy is any combination of the disciplines of physical therapy, occupational therapy, or speech-language pathology services, and is located in Section O (Items at O0400A,B,C). Nursing rehabilitation is also considered for the low intensity classification level. It consists of urinary or bowel toileting program, providing active or passive range of motion, providing splint/brace assistance, training in bed mobility or walking, training in transfer, training in dressing/grooming, training in eating/swallowing, training in amputation/prosthesis care, and training in communication. This information is found in Sections H0200C, H0500, and O0500.

Step # 1

Determine whether the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for one Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 720 minutes or more

and

One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

and

A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more.

RUG-IV ADL Score	RUG-IV Class
11-16	RUC
6-10	RUB
0-5	RUA

B. **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more

and

At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RVC
6-10	RVB
0-5	RVA

C. **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more

and

At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RHC
6-10	RHB
0-5	RHA

D. **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more

and

At least 5 days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4)

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RMC
6-10	RMB
0-5	RMA

E. **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more

and

At least 3 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)

and

Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day.

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes.

*Nursing Restorative Services
H0200C, H0500** Urinary toileting program and/or bowel toileting program
O0500A,B** Passive and/or active ROM
O0500C Splint or brace assistance
O0500D,F** Bed mobility and/or walking training
O0500E Transfer training
O0500G Dressing and/or grooming training
O0500H Eating and/or swallowing training
O0500I Amputation/prostheses care
O0500J Communication training

**Count as one service even if both provided.

RUG-IV ADL Score	RUG-IV Class
11-16	RLB
0-10	RLA

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Category, proceed to Category III.

Category III: Extensive Services
RUG-IV, 66-Group Hierarchical Classification

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

Step # 1

Rehabilitation RUG Classification

Determine whether the resident is coded for **one** of the following treatments or services:

- O0100E2 Tracheostomy care while a resident
- O0100F2 Ventilator or respirator while a resident
- O0100M2 Infection isolation while a resident

If the resident does not receive one of these treatments or services, skip to Category IV now.

Step # 2

If at least **one** of these treatments or services is coded and the resident has a total RUG-IV ADL score of 2 or more, he/she classifies as Extensive Services. **Move to Step #3. If the resident's ADL score is 0 or 1, s/he classifies as Clinically Complex.** Skip to Category VI, Step #2.

Step # 3

The resident classifies in the Extensive Services category according to the following chart:

Extensive Service Conditions	RUG-IV Class
Tracheostomy care* **and** ventilator/respirator*	ES3
Tracheostomy care* **or** ventilator/respirator*	ES2
Infection isolation* **without** tracheostomy care* **without** ventilator/respirator*	ES1

RUG-IV Classification _____

If the resident does not classify in the Extensive Services Category, proceed to Category IV.

Category IV: Special Care High
RUG-IV, 66-Group Hierarchical Classification

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

Step # 1

Rehabilitation RUG Classification

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, ADLs	Comatose and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, and G0110I1 all equal 4 or 8)
I2100	Septicemia
I2900, N0350A,B	Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, ADL Score	Quadriplegia with ADL score >= 5
I6200, J1100C	Chronic obstructive pulmonary disease **and** shortness of breath when lying flat
J1550A, others	Fever and one of the following; I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube* K0510A1 or K0510A2 Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:
(1) K0700A is 51% or more of total calories OR
(2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to Category V now.

Step # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care High. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

Step # 3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, Section D. The following items comprise the PHQ-9©:

Rehabilitation RUG Classification

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,
or
The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

Step # 4

Select the Special Care High classification based on the ADL score and the presence or absence of depression record this classification:

RUG-IV ADL Depressed RUG-IV Class

Rehabilitation RUG Classification

Score		
15-16	Yes	HE2
15-16	No	HE1
11-14	Yes	HD2
11-14	No	HD1
6-10	Yes	HC2
6-10	No	HC1
2-5	Yes	HB2
2-5	No	HB1

RUG-IV Classification _____

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Category V: Special Care Low
RUG-IV, 66-Group Hierarchical Classification

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

Step # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, ADL Score	Cerebral palsy, with ADL score >=5
I5200, ADL Score	Multiple sclerosis, with ADL score >=5
I5300, ADL Score	Parkinson's disease, with ADL score >=5
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1,D1,F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A,B,C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:
(1) K0700A is 51% or more of total calories OR
(2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.
**Selected skin treatments:
M1200A,B# Pressure relieving chair and/or bed
M1200C Turning/repositioning
M1200D Nutrition or hydration intervention
M1200E Ulcer care
M1200G Application of dressings (not to feet)
M1200H Application of ointments (not to feet)

If the resident does not have one of these conditions, skip to Category VI now.

Step # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care Low. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

Step # 3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, Section D. The following items comprise the PHQ-9©:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

Rehabilitation RUG Classification

Step # 4

Select the Special Care Low classification based on the ADL score and the presence or absence of depression; record this classification:

RUG-IV ADL Score	Depressed	RUG-IV Class
15-16	Yes	LE2
15-16	No	LE1
11-14	Yes	LD2
11-14	No	LD1
6-10	Yes	LC2
6-10	No	LC1
2-5	Yes	LB2
2-5	No	LB1

RUG-IV Classification _____

Category VI: Clinically Complex
RUG-IV, 66-Grouphierarchical Classification

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

Step # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I2000	Pneumonia
I4900, ADL Score	Hemiplegia/hemiparesis with ADL score >=5
M1040D, E	Surgical wounds or open lesions with any selected skin treatment*
M1040F	Burns
O0100A2	Chemotherapy while a resident
O0100C2	Oxygen therapy while a resident
O0100H2	IV medications while a resident
O0100I2	Transfusions while a resident

*Selected Skin Treatments
M1200F Surgical wound care
M1200G Application of dressing (not to feet)
M1200H Application of ointments (not to feet)

If the resident does not have one of these conditions, skip to Category VII now.

Step # 2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are indentified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, section D. The following items comprise the PHQ-9©:

Rehabilitation RUG Classification

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,
or
The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

Step # 3

Select the Clinically Complex classification based on the ADL score and the presence or absence of depression record this classification:

Rehabilitation RUG Classification

RUG-IV ADL Score	Depressed	RUG-IV Class
15-16	YES	CE2
15-16	NO	CE1
11-14	YES	CD2
11-14	NO	CD1
6-10	YES	CC2
6-10	NO	CC1
2-5	YES	CB2
2-5	NO	CB1
0-1	YES	CA2
0-1	NO	CA1

RUG-IV Classification _____

Category VII: Behavioral Symptoms And Cognitive Performance

RUG-IV, 66-Group Hierarchical Classification

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

Step # 1

Determine the resident's ADL score. If the resident's ADL score is 5 or less, go to Step #2.

If the ADL score is greater than 5, skip to Category VIII now.

Step # 2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for Item C0100), skip the remainder of this step and proceed to Step #3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200 Repetition of three words
C0300 Temporal orientation
C0400 Recall

Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Rehabilitation RUG Classification

Determine whether the resident is cognitively impaired. If the resident's Summary Score is less than or equal to 9, he or she is cognitively impaired and classifies in the Behavioral Symptoms and Cognitive Performance category. Skip to Step #5.

If the resident's summary score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step #3 to check staff assessment for cognitive impairment.

Step # 3

Determine whether the resident is cognitively impaired based on the staff assessment rather than on resident interview. The RUG-IV Cognitive Performance Scale (CPS) is used to determine cognitive impairment.

The resident is cognitively impaired if one of the three following conditions exists:

1. B0100		Coma (B0100 = 1) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0100I1 all = 4 or 8)
2. C1000		Severely impaired cognitive skills (C1000 = 3)
3. B0700, C0700, C1000		Two or more of the following impairment indicators are present:
	B0700 > 0	Problem being understood
	C0700 = 1	Short-term memory problem
	C1000 > 0	Cognitive skills problem
		and
		One or more of the following severe impairment indicators are present:
		B0700 >= 2 Severe problem being understood
		C1000 >= 2 Severe cognitive skills problem

If the resident meets the criteria for being cognitively impaired, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Skip to Step #5. If he or she does not present with a cognitive impairment as defined here, proceed to Step #4.

Rehabilitation RUG Classification

Step # 4

Determine whether the resident presents with one of the following behavioral symptoms:

E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral symptoms directed toward others (2 or 3)
E0200B	Verbal behavioral symptoms directed toward others (2 or 3)
E0200C	Other behavioral symptoms not directed toward others (2 or 3)
E0800	Rejection of care (2 or 3)
E0900	Wandering (2 or 3)

If the resident presents with one of the symptoms above, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Proceed to Step #5. If he or she does not present with behavioral symptoms or a cognitive impairment, skip to Category VIII.

Step # 5

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

Rehabilitation RUG Classification

Step # 6

Select the final RUG-IV Classification by using the total RUG-IV ADL score and the Restorative Nursing Count.

RUG-IV ADL Score	Restorative Nursing	RUG-IV Class
2-5	2 or more	BB2
2-5	0 or 1	BB1
0-1	2 or more	BA2
0-1	0 or 1	BA1

RUG-IV Classification _____

Category VIII: Reduced Physical Function

RUG-IV, 66-Group Hierarchical Classification

Step # 1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a RUG-IV ADL score greater than 5, are placed in this category.

Step # 2

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

Rehabilitation RUG Classification

Step # 3

Select the RUG-IV Classification by using the RUG-IV ADL score and the Restorative Nursing Count.

RUG-IV ADL Score	Restorative Nursing	RUG-IV Class
15-16	2 or more	PE2
15-16	0 or 1	PE1
11-14	2 or more	PD2
11-14	0 or 1	PD1
6-10	2 or more	PC2
6-10	0 or 1	PC1
2-5	2 or more	PB2
2-5	0 or 1	PB1
0-1	2 or more	PA2
0-1	0 or 1	PA1

RUG-IV Classification _____

Certified Bed Change Request

July 24, 2000

To: All Medicaid Certified Nursing Facility (NF) and
Medicare Certified Skilled Nursing Facility (SNF Providers

Re: Provider Letter 00-26 -- Requests for Changes in Bed Size and Changes in Designated Beds Location(s)
(Replaces Provider Letter 99-16)

The purpose of this letter is to inform providers of the Health Care Financing Administration's revised policy regarding the rules for bed changes in Medicare and/or Medicaid distinct parts. These rules are referenced in Section 3202 of the State Operations Manual and became effective June 1, 2000.

The term **distinct part** refers to a **portion** of a facility that is certified to provide either Medicare or Medicaid services or both. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. The distinct part must consist of all beds within the designated area. The distinct part can be a wing, a separate building, a floor, a hallway or one side of a corridor. Also, the distinct part need not be confined to a single location within the institution or institutional complex's physical plant. It may, for example, consist of several floors or wards in a single building, or floors or wards that are located throughout several different buildings within the same institutional complex. However, the beds in one certified distinct part must not be commingled with beds in another distinct part, or with non-participating beds.

Changes in Bed Size

A change in bed size, for the purpose of this policy, constitutes an **increase or decrease** in the size of a facility's Medicare and/or Medicaid distinct part. Certified nursing facilities may change the size of its distinct part **up to two times per cost reporting year.** Facilities may submit only one request for a change in bed size at a time. However, two decreases in bed size, within the same cost reporting year, will not be permitted. Facilities that undergo a change of ownership or change their cost reporting year are not exempt from the following bed change procedures:

- Requests for changes in bed size must be **received** in state office **45 calendar days** before
    - The first day of its cost reporting year, if the effective date is to be on the first day of the cost reporting year **or;**

- the first day of a single cost reporting quarter within the same cost reporting year, if the effective date is to be on the first day of the designated cost reporting quarter.

Note: For a facility to change the size of its distinct part **up to two times per cost reporting year**, the **first** request must be **received** in state office **45 calendar days** before the first day of the cost reporting **year**, otherwise, only one change in bed size can be made for that year.

- The request must be accompanied by floor plans and a list that identifies the current bed configuration and proposed bed configuration in order to determine whether the proposed change conforms with the rules for distinct part certification or full participation, whichever applies (see page 3, number 2 for definition of full participation).

- The request must also include a reference to the facility's cost reporting year. If there has been a change in the cost reporting year, submit a copy of the fiscal intermediary's letter approving the change in cost reporting year.

A request for a change in the bed size cannot be approved on a retroactive basis; any change is made on a prospective basis only. The state office Facility Enrollment Section is responsible for advising the intermediary and updating OSCAR/ODIE of any changes in bed size that it approves.

There are certain situations which warrant an exception to the policy. Therefore, even if a facility has been approved for changes in bed size in accordance with the policies articulated above, the facility may be granted an additional change in bed size on the basis of one of the following situations. A bed change request, based on one of the following situations must be **received** in state office **45 calendar days** before the first day of its next cost reporting quarter, along with floor plans and a list that identifies the current bed configuration and proposed bed configuration.

1. **Life Safety Code (LSC) Requirements** -- An exception may be granted if the request is to reduce the size of its distinct part to avoid being out of compliance with LSC requirements (e.g. sprinkler installation). The proposed bed configuration must be separated from the rest of the facility by a two-hour fire wall, so that there is no danger of the fire spreading from other parts of the facility not meeting the safety requirements. In this case, the proposed reduction in the size of the distinct part may be established with an effective date that is requested by the facility, but the effective date may not be earlier than the date the surveyor has verified that a two-hour fire wall exists. If the reason for the request is to avoid noncompliance with LSC requirements, a full survey by the fire authority must be performed.

2. **Elimination of Distinct Part** -- An exception may be granted if a facility wants to become fully participating. If a facility decides to become fully participating, it cannot

return to distinct part certification until, at the earliest, the beginning of its next cost reporting year.

Note: An institution is fully participating when the entire institution (all beds within the institution or institutional complex) are certified to participate in either the Medicare or Medicaid program, or both.

A bed that is both Medicare (SNF) and Medicaid (NF) certified is a dually participating (SNF/NF) bed. Dually participating beds must also be in a distinct part, that is comprised of only dually participating beds and may not be intermingled with SNF only, NF only or non-participating beds.

3. Enlargement Through Construction, Purchase or Lease of Additional Space -- An exception may be granted if the facility requests to increase the size of the distinct part to include space acquired through new construction, purchase or lease (e.g., constructing a new wing, purchasing an adjacent building or leasing a floor in a hospital).

Changes in Designated Bed Locations

A change in designated bed locations, for the purpose of this policy, refers to a change in the location of beds without a change in the size of a facility's distinct part. A facility may request a change in designated bed locations as long as there is no change in the number of beds certified to participate in the Medicare and/or Medicaid program, and the request is received in state office 30 calendar days before the actual change. In addition, the facility must submit floor plans that identify the current bed configuration and proposed bed configuration in order to determine whether the proposed change conforms with the rules for distinct part certification or full participation, whichever applies. The request must be approved before the facility makes the change. No changes may be made on a retroactive basis.

Facilities must adhere to the notification requirements found in 42 CFR 483.10(b)(11)(ii)(A) and the residents rights requirements found in 42 CPR 483.10(o) when requesting bed changes. Facilities must also adhere to the rules on bed allocation, reallocation and decertification found in TAC 19.2332 of the "Nursing Facility Requirements for Licensure and Medicaid Certification."

For any bed change request to be considered complete, all accompanying information must be received with a request. Incomplete requests will not be processed. All facilities must refer to the attached procedures ("Instructions for Requesting Changes in Bed Size in Certified Nursing Facilities and Skilled Nursing Facilities" and "Instructions for Requesting Changes in Designated Bed Location(s) in Certified Nursing Facilities and Skilled Nursing Facilities") when requesting a bed change.

Rehabilitation RUG Classification

Instructions For Requesting A Certified Bed Change In A Skilled Or Nursing Facility

The following procedures **must** be followed to process a certified bed change in a nursing facility. **Failure to follow the outlined instructions could jeopardize the requested bed change and the effective date.** Only two changes allowed per year.
Bed change requests must be **received** in State Office 45 calendar days prior to the beginning of the cost reporting quarter that falls within the same cost-reporting year.

A. The request must including the following:

   a. Name and address of facility.
   b. Facility Medicare provider number.
   c. Name of facility's fiscal intermediary.
   d. Facility fiscal year ending date.
   e. Name and telephone number of a contact person who can answer questions about the request.
   f. Tentative effective date.
   g. Cost report period i.e., first day it begins.
   h. Facility floor plan.

B. List of **current** bed types, room numbers, and capacity of each room must be submitted.

SNF - Medicare Only	SNF/NF - Dually Certified	NF - Medicaid Only	Non-Participating License Only
204-2	300-1	400-2	100-2
205-2	301-2	402-2	101-2
206-1	302-2	402-2	102-1
Total 5	5	6	5 = 21

(Totals across must equal the License Capacity of Nursing Facility)

C. List of **requested** bed change must be submitted.
   Follow same procedures as instructed in "B"

D. Date and sign request.

E. Mail request to: (*Massachusetts Only)
   Department Public Health
   David Brown
   Division of Health Care Quality
   10 West Street, 5th Floor
   Boston, MA 02111

* Mail request to State Department of Health Care Quality

Specialty Programs

Restorative Program Overview

Restorative nursing care refers to those nursing interventions that promote the resident's ability to live as independently and safely as possible. This program actively focuses on achieving and maintaining optimal physical, mental and psychosocial function.

The purpose of Restorative Programs is to increase the patients' independence, promote safety, preserve function, increase self-esteem, promote improvement in function and minimize deterioration. Specific patient goals, objectives and interventions need to be measurable. A Care Plan outlining the program is required.

In general, Restorative Nursing Programs are initiated when a resident is discharged from formalized Physical, Occupational, or Speech Rehabilitation Therapy services. A resident may also receive Restorative Services when the need arises during a custodial stay i.e., when the patient is not a candidate for a more formalized therapy program.

Restorative Nursing is a nursing function and does not require a physician's order (although obtaining an order is highly recommended by Harmony Healthcare International (HHI). In addition, the program does not require oversight by a licensed therapist. However, establishment of a close working relationship with PT/OT and SLP for optimal patient outcomes is beneficial.

To remain in a Restorative Nursing Program, the resident must maintain or retain their level of functioning. In addition, nursing rehabilitation or restorative care must meet all of the following criteria:

- The **individual problem must be clearly identified** (ex. AROM, splint or brace assistance, transfer, walking, grooming, etc.).

- **Measurable goals** (objectives) and **measurable interventions** (actions) are clearly **documented** (care planned) for each individual program. (To be measurable it must have a unit of measurement attached to it, e.g., a time-scale, a weight or a distance and it must be measured against a goal or standard). Goals should be specific, reasonable, and attainable within a prescribed time. Short-term goals should be seen in the context of long-term achievement.

- A periodic **evaluation** by a licensed nurse is present in the resident's record for each individual Restorative Program.

- Nurse assistants/aides are **trained in the techniques** that promote resident involvement in the activity.

- The activities are **supervised by a licensed nurse**, although these interventions may be carried out by nurse assistants/aides, other staff or volunteers.

- Restorative Programs may be carried out by a designated Restorative Aide or by the CNAs responsible for the daily care of the resident.

- The technique, procedure or activity practiced total at least **15 minutes during a 24-hour period** to report one day of restorative.

Restorative Nursing Program
Documentation and Communication

Discuss the importance of **Nursing** and **Aide** documentation and communication in relation to the success of existing and start up Restorative Nursing Programs for clarification and refinement of program criteria.

According to the MDS 3.0 RAI manual, a Restorative Nursing Program has:

- Measurable **objective and interventions** that must be documented in the **Care Plan** and in the medical record.
- Evidence of **periodic evaluation** by the licensed nurse must be present in the medical record.
- Oversight by a Nurse, but this does **not** require a **physician's order**.

In addition to reviewing the technical components defined within the RAI manual, is the importance of effective **Communication** and relevant **Documentation.** Some strategies that Skilled Nursing facilities across the country find helpful include, but are not limited to:

Communication

1. **Daily Huddle for Restorative Nurse and Restorative Aide** caseload review. With a focus on the evaluation, plan of care and documentation. Medical Records will be referenced during this meeting.

2. The Restorative Nursing Program actively focus on **achieving and maintaining optimal** physical, mental and psychosocial function. With that said, all disciplines should be able to state the resident's primary benefit of said program. Each meeting, the team leader **declares, validates and discusses** the intent and rationale for each resident's restorative nursing services. This mechanism promotes team knowledge, understanding and effective communication.

3. Weekly **Therapy Staff and Restorative Aide** caseload review to discuss:

    - Resident's status
    - Resident's progress towards goals
    - Documentation

Documentation

1. CNA Documentation

- Completed by the person providing the direct care
- Daily Entries
- Reviewed and **signed** by the Restorative **Nurse**
- Documented **individual goals** for each program as well as minutes delivered
- List short term goals to be achieved for the week or month

2. Restorative Nurse Documentation

- Check previous weekly documentation for baseline data or indications of **progress or decline** in performance
- Include **frequency and duration** of the training
- Include any **subjective** comments by the resident
- Include any **medical event** that occurred during the week, which may have affected performance

Continue to work the staff on continuous program improvement.

Restorative Feeding Programs
Policies and Procedures

Goal Statement

It is the goal of Harmony Healthcare and this facility that all residents are placed in appropriate dining settings in order to optimize independence and to improve quality of life.

Objective

Every resident will be screened/ or evaluated by an Occupational Therapist or Speech-Language Pathologist and recommended to the appropriate dining setting:

1. **Independent:** These residents require no assistance at meal times.

2. **Supervised:** These residents require cueing.

3. **Assisted:** These residents require some level of physical assistance such as set-up or occasional cueing.

4. **Dependent:** These residents are unable to feed themselves and must be fed by staff.

5. **Restorative Dining:** These residents currently have difficulty in feeding themselves, but it is expected that with consistent training they will be able to improve their level of independence.

6. **Restorative Feeding:** These residents have needs, which require that the Speech-Language Pathologist or Occupational Therapist carry out feeding programs. Often residents are in this program only for a short period of time and then discharged into one of the above programs.

Specialty Programs

Restorative Feeding Program
Vs.
Restorative Dining Program

The **"Restorative Feeding Program"** and the **"Restorative Dining Program"** are similar in nature and actually should be looked at as a continuum, or progressive program, that assists residents in need of the program to more independently be able to feed themselves. It is a program that requires both Occupational Therapy and nursing involvement, and while designed to assist residents, it also is an assist to nursing.

Definition of the two aspects of the program.

A. Restorative Feeding Program

This is a billable ancillary under Medicare if:

1. It is supervised by an OTR (on premises).

2. It is ordered by the physician, as with any OT order.

3. The resident, upon admission, or upon a recent documented change of condition, indicates loss of function in this ADL area, i.e., medically necessary and has potential to improve in function.

4. The service is uniformly charged to all residents who receive the service.

B. Restorative Dining Program

This is a restorative program that is carried out by nursing and may be a continuum of the Restorative Feeding Program. This is not a billable program but is an expected regulation.

1. It is supervised by nursing.

2. It does not require a physician's order, but is identified as needed by nursing and/or the interdisciplinary team.

3. It is provided to residents who are in need of more than usual encouragement and support to feed themselves, or who have reached their established goal in the Restorative Feeding Program and still are in need of a structured setting to increase their skills, or maintain what they have accomplished in this ADL area.

4. There is no separate charge for the program and it is covered in the routine cost.

Specialty Programs

Restorative Feeding Program

Program Description

Implementation of a Formal Restorative Feeding Program with established guidelines and a monitoring system can assist residents in maximizing their functional feeding skills and enhancing independence in the rehabilitation environment.

Objectives

- Promote optimal independence and safety in relation to self-feeding.
- Improve and/or maintain proper nutritional intake.
- Promote socialization and sensory awareness.
- Promote feelings of self worth and dignity.
- If appropriate, assist residents in dealing effectively with their decreased ability to function independently.

Criteria/ Resident Selection

Deficit areas to be targeted include residents exhibiting: increased food spillage, decreased coordination, decreased food intake, poor positioning at mealtime, pocketing of food, delayed swallowing, rapid eating, poor utensil usage and weight loss.

Referral Process

Residents should be referred to an Occupational Therapist or Speech-Language Pathologist for evaluation if self feeding or swallowing problems are observed or reported by any of the following:

- Nursing assessment
- Social history and assessment
- Dietary assessment
- Patient care plan review/conference
- Registered Physician Therapist recommendations
- Observations of possible need by any staff member

Who Do You Refer the Resident To?

Speech Pathologist

- Coughing or choking
- Present with aspiration pneumonia
- Difficulty chewing/swallowing
- Significant drooling
- Leaking foods/liquids from mouth/nose
- Unexplained weight loss

Occupational Therapist

- Difficulty reaching food
- Drop a significant amount of food on themselves or the floor
- Difficulty getting food from the plate to mouth
- Difficulty controlling food utensils
- Difficulty eating food in designated amount of time
- Difficulty following directions
- Disruptive/uncooperative during meals

Discipline Specific Staff Responsibilities

1. Occupational Therapy and Speech-Language Pathology

- Screen and/or evaluate selected residents.
- Provide in-service training to restorative and nursing aides on dining programs, proper feeding techniques and adaptive equipment.
- Complete care giver training for each resident.
- Notify Dietary of necessary adaptive equipment and any tray (set-up) instructions for a resident.

2. Director of Nursing (Or Other Licensed Staff as Designated)

- Responsible for appointing a member of the nursing staff to act as the Restorative Dining Program Coordinator.
- Coordination with other staff in determining the most suitable time and location for the group.
- Responsible for the overall supervision of the program and its designees.

3. Certified Nursing Assistants

- Responsible for the transport of residents to the designated dining area.

4. Restorative Dining Aide

- Responsible for implementing feeding program/plan as developed/per recommendation of OTR/L and/or SLP.
- Documenting progress on flow sheet.
- Informing Dining Program Coordinator and/or Occupational Therapist, Speech-Language Pathologist of significant change in resident's status.

5. Dietary Services

- Provision of the appropriate consistency of food.
- Provision of appropriately set up trays equipped with adaptive equipment as indicated.
- Coordination with other staff in determining the most suitable time and location for the Restorative Dining Program.
- Transportation of the trays to and from the designated area.

6. Maintenance and Housekeeping

- Responsible for maintaining designated area as needed.
- Responsible for maintenance of equipment as needed.

Program Implementation

1. Staffing

Dining Program Coordinator Responsibilities (Nursing Staff)

- Ensure follow through of recommendations.
- Weekly/monthly documentation of resident's status.
- Notifying OT/Speech of residents having difficulty in their current dining program.

2. Location

One dining room will be designated for Restorative Feeding Program on each wing/floor. Factors to be considered whenever possible:

- Allow adequate space for residents to function comfortably
- Attractive/conducive to good eating habits
- Should be as distraction free as possible
- Should provide good lighting

3. Frequency

The Restorative Feeding Program should be operating 5 days/week, 1-2 meals/day to facilitate consistency of approach and progress toward program and resident goals.

4. Time

A time for each meal should be established and consistently maintained. Residents should be in place prior to the arrival of meal tray.

5. Resident Ratio: Coverage/Staff

- The number of residents in the program will be determined by the space available in the designated area.
- The staff to resident ratio should not exceed 1:6 with ideal ratios of 1:4.
- If a need for resident placement in the Restorative Feeding Program has been identified, and there is no space available, a specific program with recommendations will be followed through in the regular dining area in the interim.

Procedure for Implementation

- Referral generated to OT and Speech (if indicated) using Restorative Feeding Referral Form.
- OT/ST will request of nursing an MD order for an "OT Feeding Evaluation" and/or "Dysphagia Eval and Rx" if indicated; once the order is obtained OT will complete a feeding evaluation within 48 hours. Specific recommendations will follow stating either:
  - resident appropriate for skilled OT intervention and/or ST
  - resident appropriate for restorative feeding program
  - resident not appropriate for restorative/skilled feeding program

Short and long-term goals will be established (as part of the OT evaluation) for residents appropriate for either skilled or non-skilled programs. A plan of treatment will be developed including specific modalities and treatment frequency. The need for adaptive equipment will also be identified.

Comprehensive in-service training/education will be provided to the Nurse Aides (7-3; 3-11 shifts) regarding set-up/feeding instructions and the proper use of adaptive equipment.

Adaptive Equipment

Whenever OT is recommending adaptive feeding equipment for a resident the following procedure should occur:

- Therapist must complete a purchase order stating:

  - Vendor (preferably Gulf or Hudson Home Health Care)
  - Item
  - Model #
  - Quantity
  - Cost

  Purchase Order should be **clearly marked** for OT.

- Purchase Order should be submitted to the facility administrator for signature approval.
- Once approved, Central Supply (designate in facility) will order equipment and notify OT upon receipt by the facility.

Providing equipment is correct, OT will dispense to the resident instructing in its proper use and arrange an in-service for the appropriate nursing staff during the resident's mealtime.

Dietary will be responsible for dispensing equipment onto the resident's tray. The restorative feeding aide/CNA should verify that the residents receive their recommended equipment on their tray.

Discontinuance

A **resident** will be **discontinued** from the Restorative Feeding Program if:

- the resident has a consistent inability to attend due to medical reasons
- the resident's preference is not to participate in the program
- the resident no longer meets the criteria for candidacy

Documentation

A. **Referral.** Referral for evaluation of residents will be provided to the OTR or SLP in writing using the dining referral form.

B. **Evaluation.** Occupational Therapy will perform evaluations using the Harmony Feeding Evaluation Form. Speech Therapy will perform Dysphagia evaluation and treatment as indicated. Completed evaluations will be signed by the resident's physician and maintained in the medical record.

C. **Restorative Aid Flow Sheet.** If discharged to Restorative Dining, the Program Coordinator should develop flow sheets for the restorative aides to correspond with the written OTR plan of treatment. Any revisions made to the resident's program by the OTR or SLP during that month should also be documented.

D. **Tray Monitor Record.** The therapist will indicate the percentage eaten of each meal on the resident's flow sheet (or other documentation as per facility policy). This form will be reviewed as necessary by the Registered Dietician. Significant information regarding acceptance of the meal should be communicated to the nursing staff.

E. **Patient Care Plan.** It is the responsibility of the Occupational Therapist (OTR/COTA) or Speech Language Pathologist to notify the Resident Care Plan Coordinator or any action taken following evaluation of the resident. Appropriate input should then be entered on the resident care plan per facility policy.

F. **Progress Notes.** Therapy will document weekly progress. The Unit Charge Nurse will document monthly progress in the progress note section of the chart. Progress notes will relate directly to the established goals and objectives.

G. **When a Resident is Discontinued.** A therapy will be written in the medical chart indicating reason for discontinuance, status at that time, and action to be taken. The Resident Care Plan will be revised to reflect the appropriate changes (i.e., transition into Restorative Dining Programs).

Restorative Feeding
Implementation checklist

1. Identify a space within the building to conduct the group. Space must be isolated from general dining and should be distraction free.

2. Meet with Nurse Management to identify a restorative CNA responsible for carrying out the restorative dining program.

3. Restorative Dining CNA should be trained on feeding/dysphagia techniques and the necessary documentation.

4. Meet with Dietary personnel to discuss tray delivery and to arrange a small supply of additional foods and beverages to be kept for the group.

5. Inventory adaptive feeding equipment and set up system with Dietary to prevent loss of equipment and to ensure that the resident will receive the necessary equipment at each mealtime.

6. In-service nursing staff on restorative feeding program utilizing.

7. Screen nursing referrals and evaluate residents as appropriate.

8. Set time and date to implement group.

Specialty Programs

Restorative Feeding Referral Form

Resident Name: _____ Room #: _____

Current Dining Program/Feeding Status: _____

_____

_____

_____

_____

Reason for referral (if any SLP boxes are checked place refer to SLP, if any OTR boxes checked refer to OTR, if both please make two copies):

Speech Pathologist

- ☐ coughing or choking
- ☐ present with aspiration pneumonia
- ☐ difficulty chewing/swallowing
- ☐ significant drooling
- ☐ leaking foods/liquids from mouth/nose
- ☐ unexplained weight loss

Occupational Therapist

- ☐ difficulty reaching food
- ☐ drop a significant amount of food on themselves or on the floor
- ☐ difficulty getting food from the plate to mouth
- ☐ difficulty controlling food utensils
- ☐ difficulty eating food in designated amount of time
- ☐ difficulty following directions
- ☐ disruptive/uncooperative during meals
- ☐ difficulty keeping hand/body upright

Comments: _____

_____

_____

_____

_____

_____ _____

Referral Source Date

Specialty Programs

Restraint Reduction

Purpose:

To eliminate or decrease restraint use within the limit.

Definition:

"Any manual or physical method, physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." (OBRA 1987)

Expected Outcomes:

To safely reduce the use of restraints with the involvement of resident and family.

The Rehab Department can assist in identifying and treatment health, functional or psychosocial problems that may be causing the condition for which restraint are ordered (falls, wandering, agitation). Interventions may include positioning, environmental modifications, and appropriate programming.

Allowable Reasons for Restraints:

1. To promote or maximize functional independence.

2. To assist in the care of life threatening medical symptoms.

3. Resident is a danger to self and/or others.

Note: The least restrictive support devices should be trailed to achieve proper body positions, balance, alignment, and contracture prevention.

Professionals Who Perform the Procedure:

1. Restraint evals are done by OT and/or PT.

2. Nursing staff in-serviced to carry out procedure post completion.

Criteria for Evaluation:

Rehab/Therapy should be referred for evaluation in restraint use when need for restraint is questioned and communicated.

1. OBRA nurse will provide the Director of Rehab with a resident restraint report at the beginning of every month.

2. Nursing will notify Director of Rehab when a physical restraint use is in question.

Clinical Process:

Once the Restraint Eval has been completed and a restraint is recommended, the therapist will in-service staff on the particular resident and a specific restraint(s). A schedule will be documented indicating duration of usage. Reassessment to be done every 3 days for 3 months and documented in Restraint Response Note. A physician's order will be obtained prior to Rehab/Therapy intervention.

Documentation:

1. A statement identifying a change of status is made by licensed staff.

2. Physicians order for eval, OT or PT. (Identified by Director of Rehab)

3. Change of condition is identified.

4. Responsible party notified of rehab intervention, a letter is sent, signed and returned.

5. Rehab documentation as appropriate.

6. Care plan update.

7. Nursing staff trained and documented.

Specialty Programs

Physical Restraint Policy

Federal Regulation:
Section 438.13: Resident Behavior and Facility Practices/Level B
Requirement: Restraints

F 221 The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

It is the policy of _____, that Physical Restraints will only be utilized when they are required to treat a resident's medical symptoms.

Prior to the use of a restraint, the Interdisciplinary Team must meet to determine if other alternatives can be used. After alternatives have been tried and failed, the least restrictive restraint for the least amount of time used to treat medical symptoms may be considered. If the resident, family member, or legal representative agrees to the use of a restraint, then the device may be used for the specific period of time for which the restraint has been determined to treat medical symptoms. The necessity of this restraint and the possibility of reduction will be assessed quarterly.

A Physical Restraint may be utilized temporarily, in an emergency, to provide necessary life saving measures – but only after less restrictive measures have been tried and assessed to be inadequate. The restraints may be used without prior approval for a brief period until the emergency is over – no longer than 24 hours.

Staff will monitor use of restraints to promote the highest practical level of physical, mental and psychosocial well-being. All restraints, when in use over a period of time, will be released at least every two hours for exercise, toileting, and a skin check in order to avoid decline in functioning.

All restraints will have a specified MD Order which includes:

- What device is to be used.
- How often device is to be used.
- The medical symptom the restraint is treating.

- The MD Order must also state that the restraint will be released and the resident's position changed at least every 2 hours. No restraint may be applied (except during an emergency) unless there is a specific MD Order.

Siderails will only be used to treat a resident's medical symptom, and only after alternatives have been attempted and have failed. **The Interdisciplinary Team must meet to assess their use and future reduction, initially and quarterly.**

If the MD Order clearly states that the siderail is **used to enhance bed mobility and other alternatives have proven ineffective,** these siderails will not be considered a restraint. However, assessment process is still required and consent.

Physical Restraints may also be used for brief periods to allow medical treatment to proceed if there is documented evidence of the resident's or the legal representative's approval of the treatment. Restraint must be removed upon completion of treatment.

Physical Restraints: Definition

"Physical Restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access one's body.

"Physical Restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove. Also included as restraints are facility practices that meet the definition of a restraint, such as:

- Using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed;
- Tucking in a sheet so tightly that a bed bound resident cannot move;
- Using wheelchair safety bars to prevent a resident from rising out of a chair;
- Placing a resident in a chair that prevents rising; and
- Placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising.

➢ **Orthotic body** devices may be used solely for therapeutic purposes to improve overall functional capacity of the resident.

➢ If it is determined that a restraint may be needed to treat a resident's medical symptoms, an **assessment will be completed** by the Interdisciplinary Team. At that time, **alternatives need to be attempted** and their success or failure documented in the resident's medical record.

➢ If alternate methods are deemed inappropriate, the resident, family members, and/or legal responsible individual will be contacted and the situation will be reviewed with them prior to restraints being utilized (unless an emergency situation arises). The resident, family member, and/or responsible legal party must sign an informed consent form for the use of the restraint.

➢ If a family, resident (if competent) and/or responsible party **refuses to sign** a consent for the use of restraint, **no** restraint may be applied.

- The specific orders for the restraint must be transcribed onto the resident's care plan. The Interdisciplinary Team must address that there may be a risk of decline in the resident with the initiation of any restraint and the care plan must reflect measures to minimize a decline. The following preventive measures should be addressed in the Care Plan:

- Skin checks
- ROM
- Toileting schedules
- Social activities
- Continual monitoring and timeframes
- Plans for future reduction

- The approaches developed during the Care Conference need to be added to the CNA Assignments (when appropriate) and monitored for compliance.

- The use of the restraints must be documented in the resident's medical record each time it is used (Flow Sheet, Nurses Notes).

- When a restraint is being utilized, it must be released every 2 hours and the resident's position must be changed.

Recliners that are used by residents solely for positioning and comfort will not be considered restraints. However, the MD Order must be very specific and the restraints must be repositioned every 2 hours, if they are unable to reposition themselves. An Informed Consent, MD Restraint Order and Assessment are not necessary.

Customized wheelchair with seat belts and/or lap trays are not considered to be restraints, but are considered to be positioning devices. The MD Order should reflect their use, and should include the following of their individualized 24-hour positioning plan.

Therapy to Nursing Communication
Restorative Nursing Rehabilitation Program Plan

Resident Name:

This resident has received skilled therapy intervention to address functional deficits. The patient will benefit from and is discharged to the recommended Restorative Nursing Rehabilitation Programs at the following level of function. The following programs have been outline with nursing. Please refer any changes, issues or concerns to nursing and therapy.

Date Program(s) Developed:

Therapist/Nurse:

Functional Area(s) Deficit:
•
•
•
•

Program(s):
•
•
•
•
•

Goal(s):
•
•
•
•

Special Precautions:
•
•
•

Equipment Needed:
•
•
•
•

Program Instructions:
•
•
•
•

Specialty Programs

Side Rail Evaluation

Patient's Name:	Facility Name:
Date of Birth: Age:	Provider Number:
Diagnoses:	ICD-10 Codes:
Admission Date:	Evaluation Date:
Onset Date:	Treatment:
Medicare Number:	Discharge Date:
Therapist:	Physician:
Prior Level of Function:	
Discharge Plan:	
Precautions:	

Utilization Assessment

Assessment	Yes	No	Comments
Has the resident expressed desire to have side rails raised while in bed?			
Is the resident currently using side rails to enable positioning or support?			
Is the resident on any medication which would require increased safety precautions?			
Does the resident have difficulty with postural hypotension?			
Does the resident have difficulty with balance or poor trunk control?			
The resident is immobile and has no independent bed mobility.			
Has the resident demonstrated poor bed mobility of difficulty moving to a sitting position on the side of the bed?			
Does the resident have a history of falls?			
Does the resident have alteration in safety awareness due to cognitive decline?			
Is the resident comatose, semi-comatose, obtunded or has fluctuations in consciousness?			
Is the resident non-ambulatory?			

Recommendations

Plan	Yes	No	Comments
Side rail usage – medical reason			
Side rail usage – functional usage			
Side rail usage – resident request			
No side rail usage			

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Side Rail Evaluation (Continued)

Treatment Plan

Frequency:	Duration:
1.	
2.	
3.	
4.	
5.	

Short-Term Goals

1.

2.

3.

4.

5.

Long-Term Goals

1.

2.

3.

4.

5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature Date _____ / _____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Specialty Programs

Facility Name Here

It is the policy of _____ that the use of physical restraints be only utilized to treat a resident's medical symptoms. The use of physical restraints is not instituted without the consent of the resident, family member, or legal representative and only after less restrictive measures have been found ineffective.

The complications associated with the use of restraints may be falls, declines in functioning, such as: chronic constipation, urinary and/or fecal incontinence, pressure sores, loss of muscle tone, loss of independence, mobility, increased agitation, loss of balance, symptoms, withdrawal or depression and reduced social contact.

I understand the purpose for and possible complications of the restraint use.

I give my informed consent that

_____

(Type)

Restraint may be used for the purpose of

_____

(Medical symptom)

for _____.

(Resident's name)

_____ I understand the risks and benefits of using and **do** consent to their use.

_____ I understand the risks and benefits of restraints and **do not** consent to their use.

_____ _____

Signed by Resident/Responsible Party Date

Physical Restraint Interdisciplinary Assessment

Date:	Physician:
Resident Name:	Diagnosis:
MDS 3.0 item triggered:	

Initial		Date	
Interim		Date	
Quarterly		Date	

Reasons restraint was applied or will be applied. (Use separate Siderail Assessment for Siderails) Medical Symptom

Specify answer: Why During what time/day How long each day

Who suggested Type Where in facility What circumstances

[Staff, Family, Resident, MD] [in room, in bed, in chair] [When unsupervised, when family leaves, etc.]

Comments:

Behavioral Factors

		Check if applies
Repetitive physical movements	[E1n]	
Any behavioral symptoms	[E4]	
Behavioral Management Program	[P2]	
Was behavior in E4 exhibited in the last 7 days? yes/no		
If no, did restraint prohibit behavior? yes/no		
If yes, review Behavior RAP		

Behavioral symptoms that relate to the following conditions: If yes

Have attempts been made to control behavioral symptoms without the use of restraint? If yes, specify.

Signature:

Based on the above review, does the resident have behavioral symptoms that impact on physical resident status? Must specifically document your findings yes or no in Summary (page 2)

Risk of Falls

Does resident have following conditions:		Check if applies
Dizziness	[E1n]	
Falls	[J4e, J4b]	
Has resident had falls with restraint on in the last 180 days?		
Anti-anxiety medications	[O4b]	
Antidepressant medications	[O4c]	

Signature:

Conditions and Treatments

Does resident have the following conditions:		Check if applies
Catheter	[H3c,d]	
Hip Fracture	[J4c lim]	
Unstable Acute Condition	[J5a,b]	
Parenteral IV and/or feeding tube	[K5a,b]	
Wound Care/treatment	[M5f,g,h,I]	
IV meds	[P1c]	
Respirator/Oxygen	[PIL]	

Physical Restraint Interdisciplinary Assessment (continued)

Functional Factors

Does restraint enhance the resident's ability to be more self-sufficient? [G1] yes/no_____ e.g. W/C belt supports trunk while resident wheels self. If yes, how does it improve independence?

Balance/Posture _____ Strength _____

Tone/Contracture _____ Transfer/Ambulation _____

Perception _____ Other _____

Signature _____

Psycho-Social Factors		Check if applies
Delirium	[B5]	
Cognitive loss/dementia	[B2,B4]	
Impaired Communication	[C4,C6]	
Sad/Anxious Mood	[E1,E2]	
Resistance to lx, meds, nourishment	[E4e]	

		Check if applies
Unmet psychosocial needs	[F1,F2,f3]	
Psychotropic drug side effects	[J1,e,f,g,l,m,c]	

Resident response to restraint _____

Alternative to restraints: Attempted: _____

Effected: Yes No If "No" what else was/is to be attempted?

Signature _____ Resident/Family wishes, values, attitude regarding restraints _____

Summary and Final Assessment

Include and discuss any factors from sections on Behavioral, Risk of Falls, Conditions and Treatments or Functional that identifies the problem, causes and risk factors and provide justification for restraint usage and need for care planning for this individual resident.

Interdisciplinary Team Recommendations for Restraint Reduction

Latest restrictive measures to be used: _____

When restraint will be applied _____ and when removed _____

Restraint Reduction / Positioning Tracking Form completed - Yes _____ No _____

Comments: _____

Signature Resident Name:

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-3738
www.harmony-healthcare.com

Restraint Reduction Evaluation

Patient's name:	**Facility name:**
Date of birth: **Age:**	**Provider number:**
Diagnoses:	**Icd-10 codes:**
Admission date:	**Evaluation date:**
Onset date:	**Treatment:**
Medicare number:	**Discharge date:**
Therapist:	**Physician:**
Prior level of function:	
Restraint description/duration/origin:	
Precautions:	

Restraint Rationale

Assessment	Yes	No	Comments
Restraint order in medical _____			
Enables and promotes greater functional independence			
Promotes highest practicable physical, mental and psychosocial well-being through a safe environment			
Resident/family prefers a restraint			
Family/legal guardian is aware of restrain order			
Notified on: _____ At_____ By_____			

Risk Factors

Assessment	Yes	No	Comments
Hx of falls			
Impaired mental status			
Impaired mobility			
Last recorded fall(s)_____			
Medication			
Orthostatic hypotension			

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Restraint Reduction Evaluation (Continued)

Medical History

Assessment	Yes	No	Comments
Changes in meds within last 30 days			
Falls within past 90 days			
Hospitalization within past 30 days			
Last seen by MD_____			

Least Restrictive Device

Restraint Approach	Yes	No	Comments (Date & Location of Paperwork)
Back to bed earlier			
Increased supervision			
Positioning pillows			
Proper body alignment			
Safety belt			
Table top			
Wedge cushion			
Other _____			

Functional Decline Since Restraint Inception

Functional Assessment	Yes	No	Comments (Date & Location of Paperwork)
Accidents w/restraint on			
Chronic constipation			
Increased agitation			
Loss of balance			
Loss of bone mass			
Loss of independent mobility			
Loss of muscle tone			
Pressure wounds			
Reduced social contact			
Symptoms of depression			
Urinary/fecal incontinence			

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Restraint Reduction Evaluation (continued)

Treatment Plan	
Frequency:	**Duration:**
1.	
2.	
3.	
4.	
5.	

Short-Term Goals	Long-Term Goals
1.	1.
2.	2
3.	3.
4.	4.
5.	5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Risks and Benefits of Various Restraints

A

Approach	Benefits	Risks
1. Geri-chair in reclined position	A. May enable resident who might otherwise be bedbound to be out-of-bed and out-of-room.	A. Limits ability to propel self if resident could otherwise roll a wheelchair. B. Is more difficult for family or staff to maneuver than a wheelchair is.
Less Restrictive Alternatives:	• Geri-chair in upright position • Wheelchair	
2. Vest restraint in wheelchair	A. Decrease immediate risk for falls and potential injuries. B. Limits wandering and potentially becoming lost. C. Can protect others from interference or aggressive behavior. D. Can increase resident's sense of security and safety.	A. Known risk for strangulation and death. B. Can compress the chest and produce a feeling of tightness. Asphyxiation (suffocation) can occur. C. Appearance of a vest restraint can decrease resident's dignity. D. Can lead to a sense of loss of control of one's life and increased agitation. E. Interferes with ability to go to toilet or get in bed at one's own will. F. Can lead to weakness and greater frailty. G. Contractures (tightness of joints) can develop.
Less Restrictive Alternative:	• Wheelchair belt of non-self-release variety	
3. Wheelchair belt of non-self-release variety	A. Decrease immediate risk for falls and potential injuries. B. Limits wandering and potentially becoming lost. C. Can protect others from interference or aggressive behavior. D. Can increase resident's sense of security and safety. E. Risk for strangulation and death diminished when compared to vest restraint. F. Less compromising to dignity than a vest restraint, as it is less visible.	A. Some residents have the skill to reach behind the wheelchair to the kickspurs to release the belt. B. Can lead to a sense of loss of control of one's life and increased agitation. C. Interferes with ability to go to toilet or get in bed at one's own will. D. Can lead to weakness and greater frailty. E. Contractures (tightness of joints) can develop.
Less Restrictive Alternative:	• Wheelchair belt of self-release variety	

B

Approach	Benefits	Risks
1. Wrist restraint	A. Prevents pulling on tubes (such as urinary catheter or feeding tube), self-irritating wounds or other skin conditions, thereby avoiding the need for reinsertion of tube or harming tissues along the path of the tube. B. Allows full movement of the finger joints of the restrained wrist.	A. Limits full movement of the wrist. B. Restraint can cause skin abrasions around the wrist, or swelling of the hand. C. Can lead to a sense of loss of control of one's life and increased agitation. D. Will limit one's independence to use a call light, relieve itches or provide other basic comfort measures for self if other arm is paralyzed or restrained. E. Will limit one's ability to independently turn in bed, relieve pressure, and provide for one's own comfort. This can increase risk for pressure ulcers.
Less Restrictive Alternative:	• Finger control mitt.	
2. Finger control mitt	A. Prevents pulling on tubes (such as urinary catheter or feeding tube), self-irritating wounds, or other skin conditions, thereby avoiding the need for reinsertion of tube or harming tissues along the path of the tube. B. Allows more movement of the wrist than a wrist restraint does. C. Allows more freedom to independently turn in bed, relieve pressure, and provide for one's own comfort.	A. Limits movement of the fingers, which can cause joint tightness. B. Can lead to a sense of loss of control of one's life and increased agitation. C. Will limit one's independence to use a call light and to provide for some other basic comfort measures for self if other arm is paralyzed or restrained.
Less Restrictive Alternatives:	• Catheter tube holder strap • Taping of tubing	
Less Restrictive Alternatives	• Remove indwelling bladder catheter • Remove feeding tube • Substitute a gastrostomy tube for a nasogastric tube	

Specialty Programs

Contracture Prevention

Purpose

To prevent the decrease in ROM, maintain skin and joint integrity, and maximize functional abilities.

Definition

Abnormal shortening of muscle tissue, rendering the muscle tissue highly resistant to stretch. It can be caused by fibrosis of the tissues supporting the muscle or the joint, or by disorders of the muscle fibers themselves. In many cases contractures can be prevented by proper exercise (active or passive) and by adequate support to the joints to eliminate constant shortening or stretching of the muscles and surrounding tissues (Encyclopedia and Dictionary of Medicare, Nursing and Allied Health).

Expected Outcome

- Prevent and/or maintain all potential contractures from forming (when possible).
- To maintain or increase PROM in currently "contracted joints" of all residents.
- To achieve and maintain the optimal condition in joint mobility and flexibility for the resident considering his/her medical diagnosis.
- To maintain skin integrity.

Professionals Who Perform the Procedure

Contracture evals are performed by OT and/or PT.

Criteria for Evaluation

1. All residents admitted will be evaluated by the Rehab Department. If the resident is assessed as having one or more contracture or are at risk for developing a contracture (based on their diagnosis, limited mobility or impaired mental status), the Rehab Department will perform a comprehensive contracture evaluation.

2. At the resident care conference (care plan review), a resident identified as having a potential for contracture will be referred to the Rehab Department for a contracture prevention evaluation.

3. Nursing may also refer when a change in tone, PROM, and/or joint flexibility is noted.

Clinical Process

1. The Therapist will complete an evaluation of the residents ROM.

    a. If it is determined that the resident has no potential for restoration of the movement, the individual will be maintained on a trained nursing program.

    b. When a contracture or potential for contracture is present, the resident will be placed on a Contracture Prevention Program. Therapy and nursing will establish goals and treatment plans for the resident. This may include but is not limited to AROM, AAROM, PROM, positioning, splints, and other positioning aides. A physician must order any treatment prior to its implementation.

2. Re-evaluation and documentation of the ROM of each resident on the program will be done by the Rehab Department weekly while the resident remains on the Contracture Prevention Program. A formal re-eval will be done monthly.

Documentation

1. A statement identifying a change of status is made by licensed staff.

2. Physicians order for eval OT and/or PT.

3. Change of condition is identified.

4. Responsible party notified of rehab intervention, a letter is sent, signed, and returned.

5. Rehab documentation as appropriate.

6. Care plan updated.

Restorative Rehab/Restorative Care (MDS Criteria)

Purpose

To determine the extent to which the resident receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g., occupational therapist, physical therapist, etc.).

Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition

Rehabilitation/restorative care – Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapies, as identified in item P1b. In addition, to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the technique that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- This category does not include exercise groups with more than four residents per supervising helper or caregiver.

Range of Motion – The extent to which, or the limits between which, a part of the body can be moved around a fixed point, or joint. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body.

Active range of motion – Exercise performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

Splint or brace assistance – Assistance can be of two types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice – Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

Bed mobility – Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

Transfer – Activities used to improve or maintain the resident's self-performance in moving between surfaces or plans either with or without assistive devices.

Walking – Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.

Dressing or grooming – Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

Eating or swallowing – Activities used to improve or maintain the resident's self-performance in feeding one-s self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

Amputation/prosthesis care – Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket).

Process

Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation, restorative care schedule, assignment, and implementation record sheet on the nursing unit.

Coding

For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The 15 minutes does not have to occur all at once. Remember that persons with dementia skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

Examples

Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a CVA experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting handsplint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, write and hand 3 times per day. The nursing assistant and Mr. V's wife have been instructed on how and when to apply and remove the handsplint and how to do the passive ROM exercises. These plans are documented on Mr. V's care plan. The total amount of time involved each day in removing and applying the handsplint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or brace assistance and Range of Motion (passive), **enter "7" as the number of days these nursing rehabilitation techniques were provided.**

Mrs. K was admitted to the nursing facility 7 days ago following repair to a fracture hip. Physical therapy was delayed due to complications and weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurse's notes that in the five days Mrs. K has been receiving training and skill practice and bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance or transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the

average time is 45 minutes. **Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.**

Mrs. J. had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity o daily living. Mrs. J's overall care plan goal is to maximize her independence in ADL's. A plan, documented on the care plan, has been developed to teach Mrs. J. how to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with Velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). **Enter "7" as the number of days training and skill practice for dressing and grooming was provided.**

Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. Together, Mrs. D and the nursing staff have set progressive walking distance goals. The nursing staff have received instruction on how to provide Mrs. D with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to apply her short leg brace followed b walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. **Enter "7" as the number o days for splint and brace assistance and training and skill practice in walking were provided.**

Experiencing a slow recovery from Guillain Barre' syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given good and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provided this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if he does not achieve the prescribed fluid and caloric intake by mouth. **Enter "7" as the number of days training and skill practice in swallowing was provided.**

Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "no". Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech language pathologist taught both Mrs. E and the nursing staff to use a communication board so that Mrs. E could communicate with staff. The communication board has prove very successful and the nursing staff, volunteers and family members are reminded by a sign over Mrs. E's bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E's care plan. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E

is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. **Enter "0" as the number of days training and skill practice in communication was provided.**

Specialty Programs

Restorative Nursing and Rehabilitation Low Criterion

Restorative Nursing Program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining **optimal physical, mental**, and **psychosocial functioning**.

The following criteria for restorative care must be met:

1. **Measurable, objective** interventions that must be documented in the **Care Plan** and in the **Medical Record**
2. Evidence of **periodic evaluation** by the **licensed nurse** must be present in the medical record
3. **RN/LPN Supervision:**
   - State-specific
   - Minimum 30 days
4. Does **not include groups** with more than **four residents** per supervision helper or caregiver
5. Evidence of Restorative Nursing **Aid Training**
6. Restorative Nursing for **2 or more of the below services, 6 or more days/week.** Count the number of the following **restorative services** provided for **15 or more minutes a day** for **6 or more** of the **last 7 days**:

H0200C, H0500** Urinary toileting program and/or bowel toileting program
O0500A,B** Passive and/or active ROM O0500C Splint or brace assistance
O0500D,F** Bed mobility and/or walking training
O0500E Transfer training
O0500G Dressing and/or grooming training
O0500H Eating and/or swallowing training
O0500I Amputation/prostheses care
O0500J Communication training

If you **combine** the above criterion with **Physical, Occupational or Speech Therapy**, then a Rehabilitation RUG Level may yield:

RLB: ADLs 11-16

RLA: ADLs 0-10

In last 7 days:

1. Received **45 minutes per week** minimum of therapy
2. **3 distinct calendar days** of therapy across disciplines
3. Restorative Nursing, **2 or more services, 6 or more days/week Key**

concepts for Case Mix States include:

- 5 times per a week for Part B
- Rehabilitation Low with Restorative
- Quarterly screening 3 weeks prior to quarterly MDS
- Communication to MDS to schedule MDS when therapy evaluations occur. May be an early Quarterly or Significant Change.

Sensory Awareness/Lifeskills Program

Purpose

Maximize sensory awareness for optimal cognitive function to allow participation in lifeskill tasks.

Definition

Arousal of the five senses used for participation in lifeskills, including ADL activities. Examples: aromas, auditory stimulation, tactile stimulation, visual stimulation, flavors

Expected Outcomes

1. Improved social interaction
2. Improved cooperation between residents
3. Improved awareness of personal appearance
4. Increased personal hygiene
5. Improved bilateral coordination
6. Improved sensory discrimination
7. Improved speed and accuracy in daily tasks
8. Increased ability to button and tie
9. Promote sharing between residents
10. Improved body scheme
11. Improved finger dexterity
12. Improved eye/hand coordination
13. An environment that promotes calmness, self-control, tolerance
14. Increased continence during program sessions
15. Increased expression of enjoyment and satisfaction

Professionals Who Perform Procedure

Formal evaluations are performed by the OTR/L, PT and SLP. The following are qualified to run sensory awareness program:

1. OTR/L
2. COTA
3. SLP
4. Recreation Therapist
5. Rehab. Aide (with direct supervision)

Criteria for Participation

Any resident who is a participant in a 1:1 Rehab therapy program with individualized goals.

Residents are required to be able to manipulate objects CTG/S and are able to maintain attention up to fifteen minutes. Functional language skills will be advantageous for residents during the group.

Setting/Equipment Specifications

Program should be help up to five times per week, and not less than three. Five to seven residents per round table, in a decreased environment stm, location of the facility.

The materials for each session should be prepared before the arrival of the participants.

Equipment will vary with each theme and will include for sensory stimulation: smells, textures, noises, flavors

Lifeskill training equipment includes: clothing, food preparation, common objects.

Clinical Process

1. Residents who are currently participating in Rehab program are eligible for placement in sensory awareness/lifeskills program.

2. Upon attainment of LTG's resident is transitioned off therapy program.

3. The therapist will inservice care taker staff on particular resident.

Documentation

For placement on active therapy program the following must occur:

1. A statement identifying a change of status is made by licensed staff.

2. Physicians order for OT/PT eval, ask Rehab staff which is appropriate.

3. Change of condition is identified.

4. Responsible party notified of rehab intervention, a letter is sent, signed and returned.

5. Rehab documentation as appropriate.

6. Care plan updated.

Specialty Programs

Therapeutic Exercise
Co-Treatment

Purpose

To improve functional performance through providing total body conditioning, a component of a complete “wellness program”.

Definition

Exercise/movement program to maintain maximum physical body performance to allow for increased independence and safety on unit and surrounding environment.

Expected Outcomes

1. Increased bilateral coordination through gross motor tasks
2. Increased eye/hand coordination
3. Functional upper extremity ROM
4. Functional trunk ROM
5. Functional lower extremity ROM
6. Increased standing balance
7. Increased ability to step forward, backward and sideward
8. Prevention of falls
9. Increased socialization
10. Normalized startle response and reaction time to environment stm.
11. Increased simple step direction following
12. Increased visual tracking
13. Increased visual attention

14. Increased self esteem

15. Functional body performance to increase/maintain independence in self-care tasks

Professionals Who Perform the Procedure

The following are qualified to run a daily therapeutic exercise co-treatment.

1. OTR/L

2. COTA

3. SLP

4. Recreation therapist

5. Rehab. Aide (with direct Supervision)

Formal evaluations are performed by the OTR/L, PT and SLP

Criteria for Participation

Resident who have been identified for therapy program in any area of decline or improvement, including but not limited to; falls, contractures, fractures, change in ADL functional status. This program is provided in addition to 1:1 therapy sessions addressing individualized patient goals.

Setting/Equipment Specifications

Open room with the appropriate number of chairs for each patient. The least amount of visual and auditory distractions from the surrounding environment. Equipment suggestions include:

- Various size balls
- Theraband
- Scarves
- Large Basket
- Parachute
- Beach ball
- Balloons
- Musical instruments

Clinical Process

1. A resident who is currently a participant in rehab therapy program is eligible for placement in the therapeutic exercise program.

2. Goals from each member's individual treatment program are addressed during each session.

3. Program is most effectively held daily in a designated area of facility.

4. Upon attainment of LTG's resident is transitioned to nursing exercise program.

5. Therapist will inservice caretaker staff on particular resident and specific goals established in resident care plan meeting.

Documentation

1. Statement identifying a change of status is made by licensed staff.

2. Physicians order to PT/OT eval, ask Rehab which is appropriate.

3. Change of condition is identified.

4. Responsible party notified of Rehab Intervention, a letter is sent, signed and returned.

5. Rehab documentation as appropriate.

6. Care plan updated.

Positioning

Purpose

Improve body alignment to maximize breathing, promote bowel and bladder control, enhance environment interaction and prevent contractures and pressure sores.

Definition

The appropriate placement of the body to relieve pressure and restore as much mobility as possible.

Expected Outcomes

1. Decrease/eliminate Stage II, III decubiti.

2. Prevent pressure sores, skin breakdown and contractures.

3. Increase mobility.

4. Promote continence.

5. Decrease pain and agitation.

Professionals Who Perform the Procedure

Wheelchair positioning evals are done by PT and OT.
Bed positioning evals done by PT and/or OT.
Rehab program to be carried out by caregivers.

Criteria for Evaluation

1. All residents admitted to the unit will be evaluated by the Rehab Department. The comprehensive evaluation will address positioning.

2. At the resident care conference (care plan review), a resident identified as having a positioning problem will be referred to the Rehab Department for a positioning/seating evaluation.

3. Caregivers may also refer when a change is noted.

Clinical Process

1. The Therapist will evaluate the resident to determine the resident's ability to change position and alleviate pressure on areas of potential breakdown. A program will be developed to be carried through by nursing staff.

2. A seating evaluation will determine if special equipment, i.e., cushions, chairs, supports are needed.

Documentation

1. Statement identifying a change of status is made by licensed staff.

2. Physicians order for an evaluation by OT and/or PT, ask Rehab staff which is appropriate.

3. Change of condition is identified.

4. Responsible party notified of Rehab intervention, a letter is sent, signed and returned.

5. Rehab documentation as appropriate.

6. Care plan updated.

Specialty Programs

Positioning for Feeding

Purpose

Improve body alignment to maximize swallowing and nutritional status while feeding, promote proper digestion, increase airway protection and respiratory control for swallowing.

Definition

Proper trunk alignment: hips to 90° and proper head/neck position: flexed to 45° in chair and bed. Patient's to remain in same position for minimum of 30 minutes after all meals.

Expected Outcomes

1. Improved safe feeding for nutritional status and appetite.

2. Improve endurance level during meals to increase appetite and weight gain.

3. Improve digestion of food/liquids.

4. Improve respiration for swallowing.

5. Decrease coughing, choking, lung congestion, aspiration pneumonia.

Professionals Who Perform the Procedure

Speech Pathologists performing Dysphagia Evaluations will contact PT/OT if positioning for feeding is hindered consistently at meals. PT/OT will conduct formal positioning evaluation and RX if deemed warranted to improve posture for swallowing.

Criteria for Evaluation

Patients with poor positioning during feeding will be observed by Speech Pathologist during Dysphagic Evaluation. If positioning problem cannot be quickly resolved by Speech Pathologist and Nursing and (or) if nursing/N.A. consistently report a patient to be difficult to position as per definition, then PT/OT will be consulted. PT/OT will then decided whether further eval/Rx is warranted.

Clinical Process

1. The PT/OT will evaluate patient to determine if patient's positioning for swallowing can be modified.

2. PT/OT will determine if patient requires specific seating or adaptive equipment to assist patient's proper alignment during feeding.

3. PT/OT will determine if patient requires Rx to improve trunk/upper body strengthening.

Documentation

1. Statement identifying a change of status is made by licensed staff.

2. Physician's order for an evaluation by OT and/or PT, ask Rehab staff which is appropriate.

3. Change of condition is identified.

4. Responsible party notified of Rehab intervention, a letter is sent, signed and returned.

5. Rehab documentation as appropriate.

6. Care plan updated.

Specialty Programs

Falls Prevention

Purpose

To promote safety and decrease risk of injury.

Definition

Most falls are caused by patient factors, primarily loss of balance, dizziness, poor vision, or the giving away of muscle and bone.

Expected Outcomes

1. Balance and strength will be improved or compensated for appropriately.
2. Hazards in the environment will be eliminated or rendered harmless.
3. Increase safe mobility for residents.

Professionals Who Perform the Procedure

The Rehab Department will assess the resident's balance, strength and coordination.

Criteria for Evaluation

The Therapist will evaluate any resident who has had significant injury from a fall and residents who have fallen two or more times within a month.

Documentation

1. A statement of falling is made by licensed staff.
2. Physician's order for an evaluation by OT and/or PT, ask Rehab staff which is appropriate.
3. Change of condition is identified.
4. Responsible party notified of Rehab intervention, a letter is sent, signed and returned.
5. Rehab documentation as appropriate.
6. Care plan updated.

Physical Therapy Fall Prevention and Assessment

Policy

[Company And/Or Facility] therapists will address fall risk on all initial evaluations of patients and will provide consultation or evaluation and treatment when indicated for residents who are triggered for rehab intervention by nursing fall policy and procedures.

Purpose

To determine a resident's risk for falls and when indicated to implement treatment plans to correct problems with balance, gait, environment and circumstances surrounding previous falls.

Procedure

1. All new admits are screened or evaluated by Physical Therapy. Fall risk will be addressed in each screen and evaluation through either a professional opinion if the patient is non-ambulatory or through the Tinetti Assessment Tool if the patient is ambulatory.

2. When a new patient triggers for being a risk for falls by the Physical Therapist, the therapist will notify nursing along with recommendations, through a communication form.

3. For resident's who fall and are concurrently on a physical therapy program, the therapist will write a situational note regarding the incident and note whether or not there have been any changes in the resident's functional condition. Recommendations for fall prevention will be provided for nursing through a communication form.

4. Nursing will notify Physical Therapy of any residents falls through out the facility either through morning report or through a communication. When a patient has fallen for the second time Physical Therapy will perform a Fall Risk Assessment and evaluate when indicated within twenty-four hours (Monday-Friday).

5. All residents who are injured during a fall will be screened by Physical Therapy within twenty-four hours (Monday-Friday).

6. When a PT evaluation is indicated the PT will:

    a. Obtain an MD order for evaluation and treatment
    b. Clarification orders for treatment will go in medical record
    c. Document any recommendations implemented in the R.C.P.
    d. Attend restraint teams on that resident when necessary

e. Instruct nursing on any changes to resident care

7. Documentation will follow [COMPANY/FACILITY] documentation procedures.

8. Upon discharge from PT program the PT will:

   a. Obtain MD order for D/C of PT services
   b. Update care plan
   c. Write PT discharge summary as per procedure

Quality Assurance

1. All falls will be tracked, as well as other pertinent information, by a member of the Physical Therapy staff.

2. A member of the Physical Therapy staff will be part of the facility's Falls CQI panel.

Fall Evaluation

Patient's Name:	**Facility Name:**
Date of Birth: **Age:**	**Provider Number:**
Diagnoses:	**ICD-10 Codes:**
Admission Date:	**Evaluation Date:**
Onset Date:	**Treatment:**
Medicare Number:	**Discharge Date:**
Therapist:	**Physician:**
Prior Level of Function:	
Discharge Plan:	
Precautions:	

Fall History

Time Frame	Number of Falls	Dates of Fall	Comments (Result of fall i.e., fractures, etc.)
Past 30 days			
Past 60 days			
Past 6 months			
Past year			

Cognitive/Perceptual Assessment

Mental Status	Check All That Apply	Comments
Not disoriented		
Orientation not determined/disoriented occasionally		
Disoriented daily		
Emotional Status		
Complacent		
Agitated		
Combative		
Sensory		
Decreased sensation or coordination in extremities		
Hearing		
Visual		
None		

Fall Evaluation (continued)

Medications

1.
2.
3.
4.
5.

Medication Potential Side Effects	Yes	No	Comments
Hypotension			
Light headedness			
Dizziness			
Cardiovascular with weakness			
Bone weakness or abnormality			

Safety

Transfers Safely	Yes	No	Comments
Knows how to transfer safety			
Ambulates/transfers safely w/caregivers			
Occasionally needs reminders			
Exhibits unsafe ambulatory transfer skills daily			

Functional

	Yes	No	Comments (Date & Location of Paperwork)
Not applicable; bedrest			
Uses device for transfer/ambulation			
Shuffled gait/balance problems			
Ill-fitting or slippery footwear			

Resident Name – Last First Middle	Attending Physician	Chart No.

Fall Evaluation (continued)

Treatment Plan

Frequency:	Duration:
1.	
2.	
3.	
4.	
5.	

Short-Term Goals

1.

2.

3.

4.

5.

Long-Term Goals

1.

2.

3.

4.

5.

Therapist Signature _____ Date ____ / ____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date ____ / ____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Tinetti Balance And Gait Evaluation

Patient's Name:	**Facility Name:**
Date of Birth: **Age:**	**Provider Number:**
Diagnoses:	**ICD-10 Codes:**
Admission date:	**Evaluation Date:**
Onset Date:	**Treatment:**
Medicare Number:	**Discharge Date:**
Therapist:	**Physician:**
Prior Level of Function:	
Discharge Plan:	
Precautions:	
Resident is seated in hard armless chair.	

Balance

Maneuver	Assessment	Rate	Score
Sitting balance	Leans or slides in chair Steady, safe	0 1	
Arise	Unable without help Able but uses are to help Able without use of arms	0 1 2	
Attempts to arise	Unable without help Able but requires more than one attempt Able to arise with one attempt	0 1 2	
Immediate standing balance (first 5 sec)	Unsteady (staggers, movies feet, marked trunk sway) Steady but uses walker or cane or grabs other object for support Steady without walker or cane or other support	0 1 2	
Standing balance	Unsteady (staggers, moves feet, marked trunk sway) Steady but wide stance (medial heels more than 4 inches apart) Narrow stance without support	0 1 2	
Nudged (subject at maximum position with feet as close together as together as possible, examiner pushes lightly on subject's sternum with palm of hand 3 times)	Begins to fall Staggers, grabs but catches self Steady	0 1 2	
Eyes closed (at maximum position No. 6)	Unsteady Steady	0 1	
Turning 360°	Discontinuous steps Continuous	0 1	
Sitting down	Unsafe (misjudged distance, falls into chair) Uses arms or not a smooth motion Safe, smooth motion	0 1 2	

Balance Score _____/16

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Tinetti Balance And Gait Evaluation (Continued)

Gait

Maneuver	Assessment	Rate	Score
Initiation of gain (immediately after told to "go")	Any hesitancy or multiple attempts to start No hesitancy	0 1	
Step length and weight	Right swing foot Does not pass left stance foot with step Passes left stance foot Right foot does not clear floor completely with step Right foot completely clears floor	0 1 0 1	
Step symmetry	Right and left step length not equal (estimate) Right and left step appear equal	0 1	
Step continuity	Stopping or discontinuing between steps Steps appear continuous	0 1	
Path (estimated in relation to floor tiles, 12 in. diameter; observe excursion of 1 foot of the course)	Marked deviation Mild/moderate deviation or uses walking aid Straight without walking aid	0 1 2	
Trunk	Marked sway or uses walking aid No sway but flexion of knees or back or spreads arms out while walking No sway, no flexion, no use of arms, and no use of walking aid	0 1 2	
Walk stance	Heels apart Heels almost touching while walking	0 1	

GAIT SCORE _____/12 **TOTAL SCORE** _____/28

Treatment Plan

Frequency:	**Duration:**
1.	
2.	
3.	
4.	
5.	

Short-Term Goals	Long-Term Goals
1.	1.
2.	2
3.	3.
4.	4.
5.	5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Communication Disorders

Purpose

To establish functional methods of communicating and language stimulation in the resident with Alzheimer's Disease or order dementing illness.

Definition

A communication disorder is a condition where the resident has difficulty using speech/language, gesture, or graphics in self-expression and/or has difficulty understanding the speech/language, gestures, or graphics used by care givers.

Expected Outcomes

1. Identification of methods that staff and family can use to best communicate with the resident.

2. Use of individually designed language stimulation programs to be conducted by care giving staff to maximize and maintain current level of language functions.

Professionals Who Perform the Procedure

Speech/Language Pathologists.

Criteria for Evaluation

1. Decrease in the ability to communicate at a prior level of ability as noted by professional staff in the medical chart.

2. Recent change in behavioral status which has necessitated a change in the care giving environment.

Criteria for Participation

1. Reasonable behavioral adaptation to the care giving environment. [Frequently must be on a new unit two weeks before the change in environment coupled with testing will not produce significant stress in the resident with Alzheimer's Disease.]

2. Ability to tolerate five minute intervals of cognitive testing without experiencing negative behaviors.

3. Staff scheduling which permits five minutes of one to one interaction with the resident daily.

4. Staff documentation of language stimulation program use.

Setting/Equipment Specifications

1. Testing should be performed in the resident's familiar environment.

2. Standardized tests should be used whenever possible. Informal evaluations may be used when the resident is unable to respond to standardized measures. Arizona Battery for Communication Disorders in Dementia is recommended.

Clinical Process

1. Care giving staff will complete screening form and communicate change to the speech pathologist.

2. Licensed staff will document change in communication status in the medical chart.

3. Licensed staff will obtain physician's order for speech/language/cognitive/swallowing evaluation.

4. Family or legal guardian will be notified of intent to evaluate.

5. Following evaluation, physician orders to train staff for implementation of individualized language program will be obtained.

6. Family and staff who will be responsible for follow through with language stimulation programs will be inserviced by the speech therapist.

7. Staff will document use of implemented programs and will report changes in performance to the speech pathologist.

Documentation

1. A statement identifying change in status is noted by licensed staff in the medical chart.

2. Physician's order to evaluate and treat, as needed.

3. Change of condition form completed.

4. Responsible party is notified of therapy intervention, a letter is sent, signed and returned.

5. Rehab documentation as appropriate.

6. Care plan updated.

7. Functional Independence Measure Completed.

Specialty Programs

Suggestions for Aphasia

Global Patient

1. Try to use whole body gesture and demonstration to improve the patient's understanding of the intended message.
2. Provide contextual cues for the patient so he can appreciate your message and show him what you are referring to (be it a photo, legal document, article of clothing, food item).
3. Use the intonation of your voice to express your feelings (happy, angry, disappointment).
4. Use facial expression along with intonation of your voice to improve the patient's understanding.
5. Discuss familiar personally relevant information with the patient. Make use of family photos and belongings.
6. Use redundancy in your spoken output – rephrase, reword, and gesture to facilitate understanding.
7. Try to establish familiar routines to enable patient to constructively participate.
8. Demonstrate the steps of a task and have patient try to imitate what you have done.
9. Keep spoken messages simple and concrete. Try to relate information with other cues (picture, object) so that the patient will have a point of reference.
10. Ask the patient yes-no questions.
11. Try to avoid asking a patient open-ended questions (i.e., What do you want? vs. Do you want to sleep?).
12. Don't switch topics too rapidly – it will only serve to confuse the patient.
13. Speak in a natural voice – the patient isn't necessarily hard of hearing.
14. Keep patient informed of personal events in his life so that he can feel that he's still a part of the family.
15. If his understanding of pictures/objects or written words is better than spoken word – accompany your spoken word with the picture or object.
16. Try not to speak too quickly. The patient may need extra time to process the information.
17. Point to the object/person that you are referring to assist patient's understanding.
18. If the patient perseverates on certain words, it may not be indicative of what he means.
19. If the patient suddenly starts to cry or laugh, it may not be a reflection of his mood, but may be a result of his stroke. Acknowledge the reaction but try to change the topic/situation to reduce the reaction.

20. Provide the patient with short spoken messages that describe what he's doing so he can relate the situation to the words.
21. Label items in the environment if the patient can read single words. Then point to the word and the item as you speak.
22. If the patient has a yes-no response that's inconsistently reliable, rephrase your statements (questions) to be sure that the response you received is reliable.
23. Encourage the use of meaningful gestures.

Fluent Aphasia
(Patients with Comprehension Deficits)

1. Discuss relevant events with the patient. Try to personalize information and relate it to the current activity.
2. Keep the language you use as familiar to the patient as possible.
3. Try to speak to the patient in as natural a manner as possible.
4. Obtain the patient's attention before speaking. Gain eye contact.
5. Encourage the patient to stop talking while you're giving directions so that there will be less competing noise. Hold your hand up, place you hand on your mouth (or patient's mouth if necessary) or stroke your head "no" to indicate that he shouldn't be speaking.
6. Provide the patient with supportive information that describes an object or situation so that he can tune-in to what you are referring to.
7. Use redundancy to help the patient appreciate what you are describing.
8. Use gesture (facial, hand, whole body) to assist the patient's being able to know what you mean.
9. Use the real object (demonstrate what you want the patient to do before he's asked to complete the task.)
10. Provide consistency and repetition in making requests so that the words can begin to be associated with what they imply.
11. Use appropriate gesture to accompany your language so that more of the information can be understood.
12. Write down a key word if it can serve as a cue for the patient.
13. Use your voice to help the patient appreciate the message – your voice can display anger, pleasure, annoyance, and impatience. The tone you use will probably be interpreted by the patient correctly and help improve his understanding of what you are saying.
14. Encourage the patient to listen to you.

15. Verify what you think the patient has said to you by rephrasing the information that you think he has said. This helps to improve the patient's feedback of the appropriate message.
16. If the patient is more successful at gesturing or showing, encourage that behavior rather than the unintelligible ramblings.
17. Allow the patient time to process information. Don't go too quickly.

Non-Fluent Aphasia

1. Provide the patient with verbal choices and have patient respond using yes/no head nod or available language.
2. Ask the patient to try to demonstrate what he wishes to say to supplement available spoken output.
3. Encourage the patient to give you a reference (object, word, gesture) so you can begin to decipher the intent.
4. Although the patient's output is limited he may understand a great deal, therefore be cautious about what you say in front of him.
5. Have the patient try to speak but if unsuccessful reinforce the attempt and try to provide some assistance, be it in the form of a question or gesture.
6. Have the patient try to repeat after you to enable some spoken success.
7. If the patient can write or point to a picture or word board, encourage him to do so.
8. Try to be familiar with what important events are happening in the person's life so you will have a better notion of what message the patient is trying to transmit.
9. Ask family to keep log of visitors/topics addressed so that you will be informed of new occurrences.
10. If the person can draw what he can't say, encourage this.
11. Try to speak a little more slowly to enable patient to follow your conversation.
12. Don't make rapid switches in topics – try to allow for smooth transitions and provide picture/object cues.
13. Don't fill-in for the patient unless he's struggling and needs your help – provide related word, or initial sound cue to facilitate his production.
14. Encourage the patient to actively agree or disagree and participate in conversations.

Glossary of Terms

Aphasia

A deficit in the ability to process symbolic materials, which exists in one and/or all stimulus modalities (auditory, visual, and tactile) and in one and/or all response modalities (speaking, writing and gesturing).

Broca's Aphasia (Non-Fluent Aphasia)

A communication deficit resulting from a lesion in the area of the third convolution in the left frontal lobe or in the fiber tracts which innervate it. It is usually accompanied by right hemiparesis or hemiplegia. The aphasia is non-fluent with sparse, telegraphic output, labored and halting production, and agrammatism (omitted word endings, articles, prepositions, etc.). Auditory comprehension can be impaired. but is usually better than speech production.

Wernicke's Aphasia (Fluent Aphasia)

A communication deficit resulting from a lesion in the auditory association area of the left temporal lobe or in the fiber tracts which connect it to other areas. The critical features of this aphasia are severely impaired auditory comprehension and fluently articulated but paraphasic speech.

Anomia (Fluent Aphasia)

A communication deficit resulting from temporal-parietal lesion, which may extend into the angular gyrus. The major feature of anomic aphasia is the prominence of word-finding difficulty in the context of fluent, grammatically well-formed speech. It differs from Wernicke's Aphasia in the absence of paraphasic speech and in the relative intactness of auditory comprehension.

Circumlocution

A "round-about" way of describing an object or an idea when the exact word can't be retrieved, e.g. describing a chair as "the thing that you sit on." Circumlocutions can vary in the amount of information conveyed, from very empty, e.g. "the thing you look at" to very descriptive, e.g. "the brown thing you are using to draw with." Circumlocutions are often taught as strategies to get around word finding problems.

Paraphasia

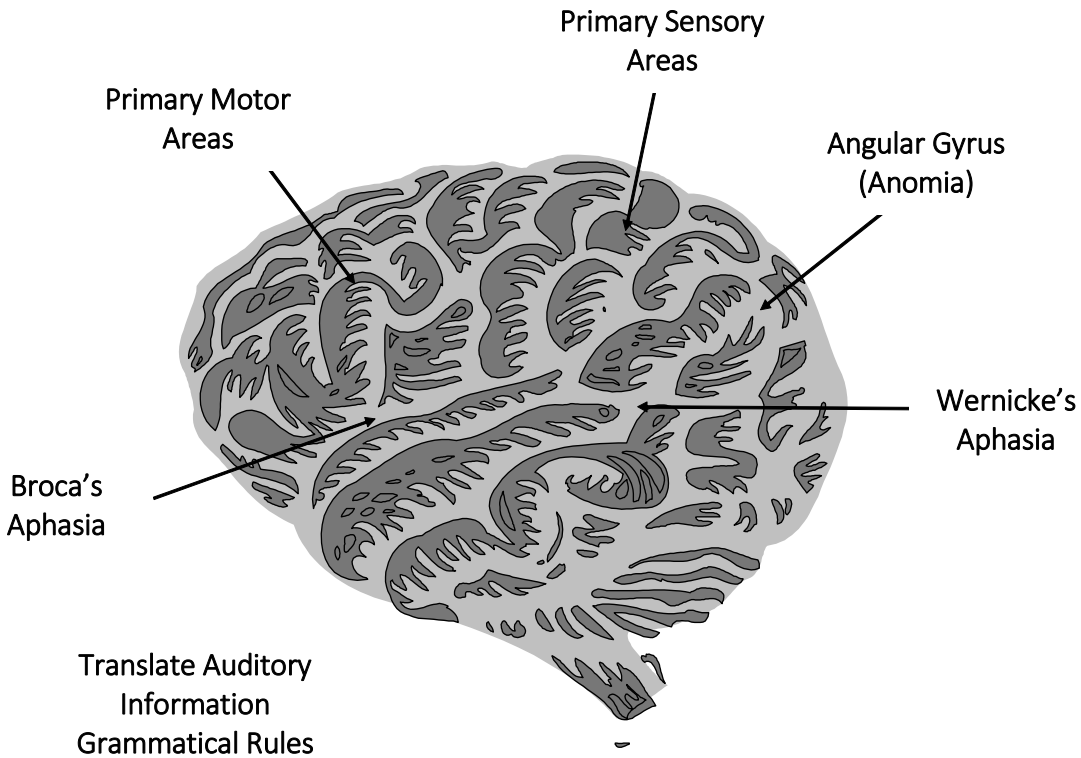
An incorrect word substitution. There are several types:

- **Phonemic.** Paraphasias sound like the intended word (also called literal)
- **Semantic.** Paraphasias resemble the intended word in meaning
- **Verbal.** Paraphasias are real words which have no relation to intended word
- **Neologisms.** Are non-words which don't resemble intended word,

e.g. Intended Word – Table
Phonemic paraphasia – pable
Verbal Paraphasia – closet
Semantic Paraphasia – chair
Neologism – poober

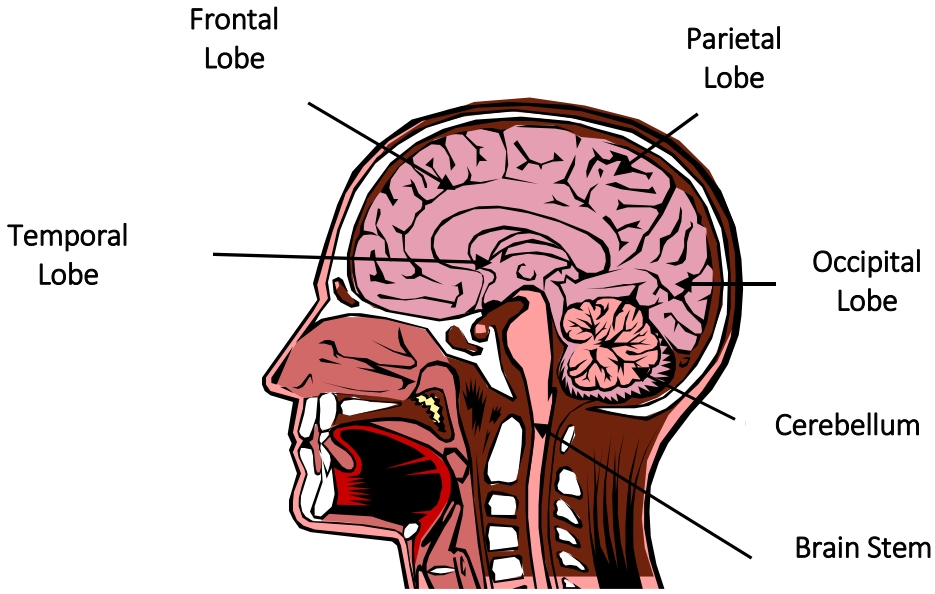
Brain Schematics

Left Hemisphere

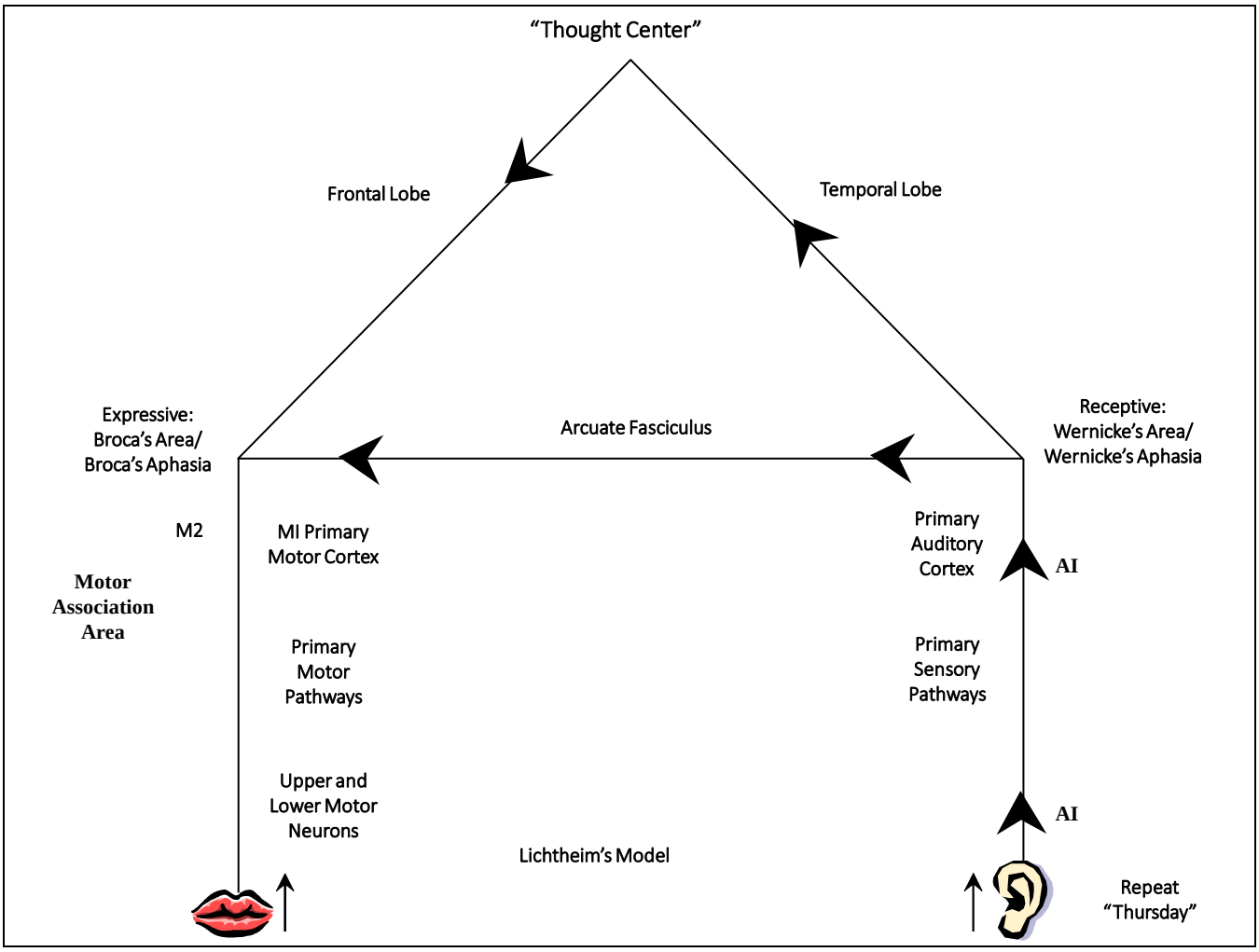


Specialty Programs

Brain Schematics



Speech Process



Auditory 1 = A1, Auditory 2 = A2, Motor 1 = M1, Motor 2 = M2

Dysphagia

Purpose

To identify and establish safe management of swallowing disorders in individuals with Alzheimer's Disease or other dementing illnesses.

Definition

Dysphagia is an impairment in the ability to swallow.

Expected Outcomes

1. Identification and implementation of safe feeding and positioning techniques that assure swallowing safely.

2. Determination of safe liquid/solid food consistencies tolerated by the resident.

Professionals Who Perform the Procedure

Speech pathologists {most frequently} and occupational therapists {less often} who have received extended training and education in the area of swallowing disorders.

Criteria for Evaluation

1. Change in swallowing status that has been noted by licensed staff in the medical record. Please refer to handout for list of symptoms.

2. Admission to the facility with noted dementing illness diagnosis.

Criteria for Participation

1. Oral nutritional intake.

2. For those residents who nutrition is sustained by feeding tubes, swallowing evaluation results which indicate that a weaning process to oral nutritional intake is safe.

Setting/Equipment Specifications

1. Bedside/informal evaluations will be performed in the resident's long-term care environment. Evaluation tools utilized are determined by the swallowing therapist.

2. Videofluoriscopic evaluation {modified barium swallow} will be performed in a hospital setting. Being taken out of the familiar long-term care facility is typically very confusing and emotionally demanding for the resident with dementia, and this testing should only be undertaken upon recommendation by the swallowing therapist after consultation with the care giving staff.

Clinical Process

1. All nursing staff provided with inservice training at least yearly for identification of residents with swallowing impairments.

2. Dietary staff and swallowing therapist to develop and use a recognizable dietary consistency outline which would clearly indicate which food items and types of food preparation are acceptable for pureed, ground, mechanical soft and regular food consistencies. Please refer to suggested guidelines.

3. Nursing will complete a subjective assessment for swallowing upon admission and at quarterly Medicare review.

4. Nursing will document any swallowing difficulties in the medical chart.

5. Nursing will notify swallowing therapist of perceived change in swallowing status and a physician's order to evaluate will be obtained upon determination of need.

6. Family will be notified of the intent to evaluate.

7. Results of the evaluation will determine the following:

    - Continued safety of oral intake.
    - The need for videofluoroscopic evaluation.
    - Safe dietary consistency for the next and subsequent meals.
    - Safe positioning while eating/drinking.
    - Further therapeutic intervention for improve swallowing function or establishment of a functional maintenance program.
    - Amount and type of staff training.

8. Individualized printed protocol for the resident will be distributed to dietary staff, nursing aides, nurses, activity staff, medical records, other rehabilitation staff, and will be posted in the Plan of Care.

9. Swallowing therapist will provide training for primary care givers and all who will be responsible for the resident's feeding.

10. When the condition has stabilized and is not expected to change soon, a physician's order for the recommended dietary consistency will be obtained at the time of discharge.

Documentation

In accordance with Medicare and facility regulations.

Specialty Programs

Hearing Impairment

Purpose

Procedures to improve hearing and communication ability in residents with Alzheimer's Disease of other dementing illnesses.

Definition

In the context of communication, it is decreased ability to perceive sound in the speech range of 1K to 8K, with most speech sounds occurring from 2K to 4K.

Expected Outcomes

1. To provide augmented devices, such as hearing aids or other amplification systems as recommended upon completion of the evaluation.

2. Provide staff and family with management techniques for altering environment to improve the communication of the hearing handicapped resident.

Professionals Who Perform the Procedure

Audiologists perform hearing evaluations and dispense hearing aids. Audiologists and speech pathologists implement aural rehabilitation programs.

Criteria for Evaluation

1. Change in hearing ability noted by licensed professional staff in the medical chart.

2. Unmanaged hearing loss identified by routine audio logy consult upon admission to the facility, or hearing loss identified by licensed staff in the medical record upon admission to the long-term care facility.

Criteria for Participation

1. Cognitive ability to respond to testing signals.

2. Ability to tolerate hearing aids in those residents where the device is recommended by the audiologist.

Setting/Equipment Specifications

1. Preferred testing site for this population is the long-term care facility, with the audiologist using portable audio metric equipment. Testing in the audiologist's office should only occur if it will not adversely affect the resident's behaviors.

2. All procedures to be performed in compliance with acceptable practice procedures outlined be the American Speech and Hearing Association.

Clinical Process

1. Each facility will provide nursing staff training for performing otoscopic evaluations of current residents and new admission. It is recommended that current residents have an otoscopic evaluation at least once every six months to detect cerument impaction in its early and more manageable stages.

2. Nursing will perform otoscopic assessment. If any condition exist that is not normal or if cerumen impaction is noted, treatment will be determined by the residents' physician or an otolaryngologist. Further hearing acuity assessment will not be undertaken until the medical condition has been remediated or until it has been determined that the condition cannot be remediated and further assessment is warranted and not medically contraindicated.

3. Nursing will complete a subjective assessment form. {Please refer to attached suggestion form}. It is recommended that this form be completed at least once every six months in conjunction with the otoscopic assessment, or at quarterly Medicare meetings.

4. Should a hearing acuity problem be identified by the nursing staff, the speech pathologist will be consulted and a decision will be made as to whether a complete speech and language evaluation along with a hearing screening is warranted, or whether an audiologist only should be contracted to perform an audiological assessment.

5. A physician's order is obtained for the speech/language/hearing evaluation or the audiologist's evaluation.

6. The family is notified of the intent to evaluate.

7. Results of the hearing evaluation and behavioral profile will indicate if a listening device is warranted.

8. Should a hearing aide be recommended and obtained, staff training for use and care of the hearing aide will be carried out by the audiologist, in compliance with ASHA regulations. Any aural rehabilitation or speech reading treatment will be performed by the staff speech

pathologist. Although this would most like be on a very limited basis, depending on the degree of loss of cognitive functioning. In most cases aural rehabilitation would not be undertaken.

Documentation

1. Statement identifying the problem or a change of status is noted by licensed staff in the medical chart.

2. A physician's order for an audiological and/or speech pathology evaluation is obtained.

3. Change of condition form is completed.

4. Responsible party is notified of therapy intervention, a letter is sent, signed and returned.

5. Rehab documentation as appropriate.

6. Care plan is updated and Functional Independence Measure is completed.

Augmentative Evaluation

Harmony has devised the following augmentative evaluations to be utilized when patients present with deficits or barriers requiring specialized assessment and goal setting.

This section contains the following evaluations:

1. Eating Performance Evaluation
2. Feeding Performance Evaluation
3. Contracture Evaluation
4. Splinting Evaluation
5. Seating/Postural Evaluation
6. Seating and Mobility Evaluation
7. Restraint Evaluation
8. Nursing Rehabilitative/Restorative Care
9. Wound Evaluation
10. Swallowing Evaluation
11. Lower Level Skills
12. High Level Skills
13. Home Evaluation
14. Home Evaluation General Considerations
15. Ramping Guidelines

Augmentative Evaluation

Eating Performance Evaluation

Patient's Name:	**Facility Name:**
Date of Birth: **Age:**	**Provider Number:**
Diagnoses:	**ICD-10 Codes:**
Admission Date:	**Evaluation Date:**
Onset Date:	**Treatment DX:**
Medicare Number:	**Discharge Date:**
Therapist:	**Physician:**
Prior Level of Function:	**Weight:**
Discharge Plan:	**Teeth/Dentures:**
Precautions:	**Dominance:** ☐ **Right** ☐ **Left**

General Orientation

Assessment Areas	Yes	No	Comments
Confused, does not respond to intervention or name			
onfused, response to verbal cues, name (continual intervention, uses utensils inappropriately, eats others' food, leaves table)			
Oriented with occasional intervention (functional for environment)			
Oriented to self and situation			

Predominant State Of Consciousness

Assessment Areas	Yes	No	Comments
Sleeping			
Variable-alert to semi-alert to sleeping			
Passive/alert, no emotional reaction, even when approached			
Active/alert, initiates actions, changes and/or communication			

General Body Alignment

Body Alignment	Yes	No	Comments
Unsatisfactory 75-100% of the time (almost always)			
Unsatisfactory 50% of the time (inconsistent)			
Satisfactory with some assistance/adaptations			
Consistently satisfactory 90% of the time (no adaptations)			
Head Alignment	**Yes**	**No**	**Comments**
Unsatisfactory 75-100% of the time (almost always)			
Unsatisfactory 50% of the time (inconsistent)			
Satisfactory with some assistance/adaptations			
Consistently satisfactory 90% of the time (no adaptations)			

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Eating Performance Evaluation (Continued)

Behavior

Body Alignment	Yes	No	Comments
Unsatisfactory 75-100% of the time (almost always)			
Unsatisfactory 50% of the time (inconsistent)			
Satisfactory with some assistance/adaptations			
Consistently satisfactory 90% of the time (no adaptations)			
Response to Food When Presented	**Yes**	**No**	**Comments**
No response			
Disinterested (notices but looks away, states "not hungry")			
Inappropriate (throws, mixes, plays with food or utensils)			
Interest shown only after task has been initiated for patient			
Initiates feeding process			
How Much Reinforcement Needed to Eat	**Yes**	**No**	**Comments**
Continual			
Often (50-75% of the time)			
Occasional (25-49% of the time)			
Rare to never			
Response to Environment	**Yes**	**No**	**Comments**
No response			
Occasional response (looks at object with verbal cueing)			
Variable response (looks around spontaneously, no focus)			
Most often notices environment spontaneously			
Notices environment and responds consistently			
Non-Verbal Interaction With Others	**Yes**	**No**	**Comments**
None – no response			
Brief eye contact made following verbal or tactile stimulus			
Maintained eye contact following verbal or tactile stimulus			
Alert with appropriate eye contact and facial expressions (no gestural communication)			
Alert with appropriate eye, facial and gestural communication			
Verbal Interaction With Others	**Yes**	**No**	**Comments**
None			
Verbal responses inappropriate, no initiation of conversation			
Verbally initiates, but inappropriate (jargon, disoriented)			

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Eating Performance Evaluation (Continued)

Verbal Interaction With Others (continued)	Yes	No	Comments
Verbal responses are appropriate but does not initiate			
Verbal responses are appropriate and initiates conversation			

Intake

Food Intake	Yes	No	Comments
0-10%			
09-25%			
24-50%			
49-75%			
74-100%			

Fluid Intake	Yes	No	Comments
0-10%			
09-25%			
24-50%			
49-75%			
74-100%			

Skill Level/Coordination

Percentage of Meal Fed by Self (following setup)	Yes	No	Comments
0-10%			
09-25%			
24-50%			
49-75%			
74-100%			

Efficiency of Eating	Yes	No	Comments
Excessively messy (75% of food on lap, floor, bib, table)			
Messy (50% of food on lap, floor, bib, table)			
Some mess (25% of food on lap, floor, bib, table)			
Neat (minimal mess)			

Time Required to Eat	Yes	No	Comments
>60 minutes			
60 minutes			
45 minutes			
10-15 minutes (too fast)			
20-30 minutes			

Eating With Fingers	Yes	No	Comments
No attempts with fingers or utensils			
Infrequent, awkward – pt. Inappropriate for utensils			
Most of meal – mess, no utensils used			

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Eating Performance Evaluation (Continued)

Eating With Fingers (continued)	Yes	No	Comments
Satisfactory eats complete meal with fingers, finger food diet			
Eats food appropriately with appropriate use of utensils			
Use of Utensils: Fork, Spoon (check one or both)	**Yes**	**No**	**Comments**
No attempts			
Attempts to assist, awkward			
Brings food to mouth on utensil, frequent spills			
Scoops/spears food, utensil to mouth, some spilling			
Handles utensil appropriately, satisfactorily			
Ability to Cut Food	**Yes**	**No**	**Comments**
Not applicable, food is blended, soft			
Food is cut for patient, no attempt			
Able to cut with fork			
Unilateral use of knife or adapted utensil			
Bilateral use of fork and knife			
Use of Cup/Glass	**Yes**	**No**	**Comments**
No attempt			
Needs some assist to prevent spills or carry wt. of cup			
Independent with adapted cup or straw setup			
Independent, 1 or 2 hands			

Treatment Plan

Frequency:	**Duration:**
1.	
2.	
3.	
4.	

Short-Term Goals	Long-Term Goals
1.	1.
2.	2
3.	3.
4.	4.
5.	5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First Middle	Attending Physician	Chart No.

Augmentative Evaluation

Feeding Performance Evaluation

Patient's Name:		**Facility Name:**	
Date of Birth:	**Age:**	**Provider Number:**	
Diagnoses:		**ICD-10 codes:**	
Admission Date:		**Evaluation Date:**	
Onset Date:		**Treatment DX:**	
Medicare Number:		**Discharge Date:**	
Therapist:		**Physician:**	
Prior Level of Function:		**Weight:**	
Discharge Plan:		**Teeth/Dentures:**	
Precautions:		**Dominance:** ☐ **Right** ☐ **Left**	

Cognition

Assessment Areas	Yes	No	Comments
Alert			
Oriented			
Responds to Environment			
Follows Directions			
Motivated			
Social Appropriateness			
Attention Span			

Positioning

Assessment Areas	Yes	No	Comments
Good head alignment			
Good trunk alignment			
Feet supported			
Type of hair			

Upper Extremity Function

Assessment Areas	Yes	No	Comments
Opens packages			
Uses condiments appropriately +116			
Reaches utensils			
Grasps utensils			
Cuts food			
Scoops food with utensils			
Brings food to mouth with utensils			
Returns utensils to tray			
Manages finger foods			
Uses adaptive equipment			
Reaches cup			

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Feeding Performance Evaluation (Continued)

Upper Extremity Function (continued)

Assessment Areas	Yes	No	Comments
Grasps cup			
Brings cup to mouth			
Returns cup to tray			
Drinks from a straw			

Oral Intake

Assessment Areas	Percentage/Time	Comments
Total food intake	%	
% self feeds	%	
Tactile assist required	%	
Verbal assist required	%	
Amount of spillage	%	
Time required to eat		
Food preferences	N/A	

Treatment Plan

Frequency:	Duration:
1.	
2.	
3.	
4.	
5.	

Short-Term Goals	Long-Term Goals
1.	1.
2.	2
3.	3.
4.	4.
5.	5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last First Middle	Attending Physician	Chart No.

Augmentative Evaluation

Swallowing Initial Evaluation

Patient's Name:		☐ **Part A** ☐ **Part B** ☐ **Other**	
Date of Birth:	**Age:**	**Provider Number:**	
Diagnoses:		**ICD-10 codes:**	
Admission Date:		**Evaluation Date:**	
Onset Date:		**Treatment DX:**	
Medicare Number:		**Discharge Date:**	
Precautions:	☐ 0_2 ☐ Diet Restrictions ☐ Cardiac ☐ Allergies ☐ Other		
Medical History (include hospitalization with dates, complications, most recent barium swallow):			
Prior Level Of Function/Social History (include self-feeding assist level, current diet, dental status):			

Assessment Areas	WFL	Impaired	Comments
Alertness:			
Mastication:			
Cognition:			
Drooling:			
Gag Reflex:			
Voice Quality:			
Oral Phase (include bolus formation and bolus control):			
Pocketing:			
Oral Sensitivity:			
Pharyngeal Phase: Include timing of Swallow reflex and Laryngeal elevation:			
Throat Clearing:			
Coughing/Choking:			
Endurance:			
Respiratory:			
Safety:			
Weight Loss:			

Resident Name – Last	First	Middle	Therapist Signature	Date:

Swallowing Initial Evaluation (continued)

Swallowing Recommendations:

Solid Consistency: **Liquid Consistency:**

Supervision Level:

Short-Term Goals (Include Time Frames)

1.

2.

3.

4.

Long-Term Goals (Include Time Frames)

1.

2.

3.

4.

Treatment plan:

☐ Swallow Treatment 92526

Frequency:_____Duration:_____

Therapist Signature: Date _____ / _____ / _____

Certification Dates (should reflect up to a maximum 30-day period): to

I have reviewed this Plan of Care and certify a need for the above services.

Physician Signature

Date _____ / _____ / _____

Discharge Summary

Resident Name – Last First Middle Therapist Signature Date:

Augmentative Evaluation

Contracture Evaluation

Patient's Name:		**Facility Name:**	
Date of Birth:	**Age:**	**Provider Number:**	
Diagnoses:		**ICD-10 Codes:**	
Admission Date:		**Evaluation Date:**	
Onset Date:		**Treatment DX:**	
Medicare Number:		**Discharge Date:**	
Therapist:		**Physician:**	
Prior Level of Function:			
Discharge Plan:			
Precautions:			

Assessment

Contracted Area	Comments
Passive Range of Motion	
Active Range of Motion	
Cognitive Status	
Sitting Posture	
Supine Posture	
Functional Abilities	
Joint Conditions	
Neuromuscular Integrity	

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Contracture Evaluation (continued)

Treatment Plan

Frequency:	Duration:
1.	
2.	
3.	
4.	
5.	

Short-Term Goals

1.

2.

3.

4.

5.

Long-Term Goals

1.

2.

3.

4.

5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First Middle	Attending Physician	Chart No.

Augmentative Evaluation

Splinting Evaluation

Patient's Name:	**Facility Name:**
Date of Birth: **Age:**	**Provider Number:**
Diagnoses:	**ICD-10 codes:**
Admission Date:	**Evaluation Date:**
Onset Date:	**Treatment DX:**
Medicare Number:	**Discharge Date:**
Therapist:	**Physician:**
Prior Level of Function:	
Discharge Plan:	
Precautions:	

UE Evaluation – Dominance ☐ Right ☐ Left

Assessment Areas	Right	Left
Active ROM		
Passive ROM		
Strength		
Sensation		
Resting Posture		
Tone		
Swelling/Edema (volumetric reading)		
Skin Integrity		
Pain		
Contracture		
Splint History		
Current Splint		

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Splinting Evaluation (continued)

Treatment Plan

Frequency:	Duration:
1.	
2.	
3.	
4.	
5.	

Short-Term Goals

1.
2.
3.
4.
5.

Long-Term Goals

1.
2.
3.
4.
5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First Middle	Attending Physician	Chart No.

Augmentative Evaluation

Seating/Postural Evaluation	
Patient's Name:	**Facility Name:**
Date of Birth: **age:**	**Provider Number:**
Diagnoses:	**ICD-10 Codes:**
Onset Date:	**Evaluation Date:**
HIC Number:	**Physician:**
Reason for Referral:	
Prior Level of Function:	
Discharge Plan:	
Precautions:	

Assessment

Assessed Areas	Comments	
Passive Range of Motion	**Right** UE	LE
	Left UE	LE
Active Range of Motion	**Right** UE	LE
	Left UE	LE
Sensation	UE:	LE:
Pain		
Cognitive Status		
Sitting Posture		
Current Seating System		
Supine Posture/Resting Posture		
Functional Abilities		
Joint Limitations/ Contractures		
Neuromuscular Integrity/ Muscle Strength		

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Seating/Postural Evaluation (Continued)

Treatment Plan

Frequency/Duration: **Estimated Length of Program:**

Problem List:

1.
2.
3.
4.

Short-Term Goals

1.
2.
3.

Long-Term Goals

1.
2.
3.

Additional Comments

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Seating And Mobility Evaluation Form

Patient's Name:		**Facility Name:**	
Date of Birth:	**Age:**	**Provider Number:**	
Diagnoses:		**ICD-10 Codes:**	
Onset Date:		**Evaluation Date:**	
HIC Number:		**Physician:**	
Reason for Referral:			
Prior Level of Function:			
Discharge Plan:			
Precautions:			
Was A Physical Or Occupational Therapist Involved In The Evaluation		☐ **Yes**	☐ **No**

Request For Equipment

- ☐ Manual Wheelchair – Fill out assessment form
- ☐ Powered Wheelchair – Fill out assessment form
- ☐ Seating Components – Fill out assessment form
- ☐ Repairs/Materials – Move directly to Recommendation/Justification Page

Needs Assessment

Client Goals:

Pertinent Surgical History:

Pertinent Medical History:

Other Assistive Technology Needs in Chair (i.e.; augmentative communication device)

Activities Of Daily Living

Performed in Wheelchair			Skill Level			Equipment Utilized
Feeding	☐ Yes	☐ No	☐ Independent	☐ Assisted	☐ Dependent	
Dressing	☐ Yes	☐ No	☐ Independent	☐ Assisted	☐ Dependent	
Bathing	☐ Yes	☐ No	☐ Independent	☐ Assisted	☐ Dependent	
Toileting	☐ Yes	☐ No	☐ Independent	☐ Assisted	☐ Dependent	
Transfers	☐ Yes	☐ No	☐ Independent	☐ Assisted	☐ Dependent	

Client's Present Wheelchair And Seating System

No present wheelchair ☐			
Wheelchair Manufacturer		Model:	
Seat depth	Seat width	Back height	Overall width
Overall length	Overall height of client in chair		Seat height from floor
Present seating/cushion			Age:

Transportation

Automobile:	☐ Independent	☐ Dependent	With Lift: ☐ Yes ☐ No
Type:			
Van:	☐ Independent	☐ Dependent	With Lift: ☐ Yes ☐ No
Type:			
Does client drive from wheelchair?		☐ Yes	☐ No
Public Transportation	☐		
No Transportation	☐		

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Formatted: Centered

Augmentative Evaluation

Seating And Mobility Evaluation Form

Environment

Accessibility into Home:	☐ Ramp	☐ Level	☐ Steps
Is living space accessible to current equipment?	☐ Yes	☐ No	
Setting:	☐ Rural	☐ Urban	☐ Suburban

Physical Evaluation

Orthopedic Involvement

List any ROM limitations that would prevent client from obtaining normal seated posture or is otherwise relevant to seating or mobility system

FL = Flexible; FX = Fixed – If Fixed, add approximate degrees of movement

Pelvis	FL	FX	Left Hip	FL	FX	Right Hip	FL	FX	Left Knee	FL	FX	Right Knee	FL	FX
Obliquity			Flexion			Flexion			Flexion in sitting			Flexion in sitting		
Rotation			Extension			Extension								
Ant. Tilt			Int Rotation			Int Rotation			Extension in sitting			Extension in sitting		
Post. Tilt			Ext.Rotation			Ext Rotation								
			Abduction			Abduction								
			Abduction			Abduction								

Left Ankle	FL	FX	Right Ankle	FL	FX	Trunk	FL	FX	Head	FL	FX
Eversion			Eversion			Scoliosis			Extension		
Inversion			Inversion			Kyphosis			Flexion		
Dorsiflex			Dorsiflex			Lordosis			Tilt		
Plantarflex			Plantarflex			Rotation			Rotation		

Passive Range of Motion

	R	L	Comments		R	L	Comments
Shoulder				Fingers			
Elbow				Thumb			
Wrist							

Neuromotor Status

Tone: Indicate any difference between Right and Left sides under Mild/Moderate/Severe

	Upper Extremities			Lower Extremities			Trunk		
	MILD	MOD	SEVERE	MILD	MOD	SEVERE	MILD	MOD	SEVERE
Hypertonicity									
Hypertonicity									
Athetoid									
Ataxic									
Intention Tremor									
Non-Intention Tremor									
Rigidity									

Pathological Reflexes

Asymmetrical Tonic Neck Reflex	Positive Supporting
Symmetrical Tonic Neck Reflex	Startle
Tonic Labyrinthine Supine	Extensor Thrust
Tonic Labyrinthine Prone	Other (explain)

Do tone/reflexes hinder function and/or ability to sit?

Gross Motor Function

Head Control	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Normal
Trunk Control	☐ None	☐ Poor	☐ Fair	☐ Good	☐ Normal

Functional Strength Limitations:

Upper Extremities	Lower Extremities:

Resident Name – Last First Middle Attending Physician Chart No.

Augmentative Evaluation

Seating And Mobility Evaluation Form

Sensory Status				
Vision:	☐ Blind	☐ Impaired w/Correction	☐ Within Normal Limits	
Hearing:	☐ Deaf	☐ Impaired w/Correction	☐ Within Normal Limits	
Skin Condition				
Has the client ever had surgical intervention for sores?				
List locations and dates:				
Pressure relief	☐ Independent	☐ Dependent		
Pressure relief method used				
Sensation:	☐ Absent	☐ Impaired	☐ Intact	
Where Absent or Impaired:				
Current Pressure Problems:	☐ None	☐ Sacral	☐ Trochanter R/L	☐ Ischial R/L ☐ Heel R/L
☐ Spinous Process (which ones?)				
Is surgical intervention planned?		If Yes, when?		
Type of surgery planned				
Is client at high risk for pressure sores?		If Yes, why?		
Equipment Trials				
Was the client tried in equipment?	☐ Yes	☐ No		
Were the client's goals attainted?	☐ Yes	☐ No		
Were additional goals realized?	☐ Yes	☐ No		
Comments:				
Equipment Recommendation/Justification				
Seating System				
Seat Component:				
Type:				
Comments:				
Lateral Pelvic Component:				
Type:				
Comments:				
Medial Thigh Component:				
Type:				
Comments:				
Anterior Pelvic Support:				
Type:				
Comments:				
Back Component:				
Type:				
Comments:				
Lateral Thoracic Supports:				
Type:				
Comments:				
Anterior Thoracic Support:				
Type:				
Comments:				
Headrest:				
Type:				
Comments:				
Foot Support (custom)				
Type:				
Comments:				

Resident Name – Last	First	Middle	Attending Physician	Chart No.

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Seating And Mobility Evaluation Form

Seating System (continued)		
Upper Extremity Support:		
Type:		
Comments:		
Other Seating Equipment:		
Type:		
Comments:		
Wheelchair		
Propulsion	☐ Independent	☐ Dependent
Wheelchair type ☐ Powered	☐ Manual	
Manufacturer Model		
Seat Width	Seat Depth	Frame Length
Seat to Floor Height	Comments:	
If powered: Method client uses to control chair (i.e., joystick, sip and puff)		
Comments:		
Electronics (i.e., programmable/non-programmable)		
Comments:		
Custom Mounting of Controls Necessary		
Comments:		
Frame Style:		
Comments:		
Armrest style:		
Backrest Style:		
Comments:		
Footrest Hanger Style:		
Comments:		
Foot Plate Style:		
Comments:		
Caster Type:	Caster Size:	
Comments:		
Axle Style:		
Comments:		
Rear Wheel Type:	Rear Wheel Size:	
Comments:		
Handrim Type: Handrim Size:		
Comments:		
Wheel Lock Style:		
Comments:		
Accessories:		
Comments:		
Orientation In Space		
Power Tilt ☐	Power Recline ☐	
How is the Client Operating?		
Comments:		
Manual Tilt ☐	Manual Recline ☐	
Comments:		

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Restraint Evaluation

Patient's Name:	**Facility Name:**
Date of Birth: **age:**	**Provider Number:**
Diagnoses:	**ICD-10 Codes:**
Admission Date:	**Evaluation Date:**
Onset Date:	**Treatment DX:**
Medicare Number:	**Discharge Date:**
Therapist:	**Physician:**

Prior Level of Function:

Discharge Plan:

Precautions:

Medications that impact muscle tone, balance or motor function:

Manual Muscle Testing

Assessment	Right			Left			Comments
	Strength	AROM	PROM	Strength	AROM	PROM	
Hip reflexors							
Hip extensors							
Hip abductors							
Knee extensors							
Knee flexors							
Ankle dorsiflexors							
Ankle plantarflexors							

Clinical Factors

Assessment Areas	Yes	No	Comments
Documented osteoporosis			
Documented osteopenia			
History of facture(s)			
Limited range of motion contributing factor			
Postural abnormalities in sitting			
Postural abnormalities in standing			
Complaints of dizziness or lightheadedness sit to stand?			
Complaints of dizziness or lightheadedness supine to sit?			

Resident Name – Last First Middle	Attending Physician	Chart No.

Augmentative Evaluation

Restraint Evaluation (Continued)

Comment	
Usual footwear	
Functional transfer ability	
History of problem	

Treatment Plan	
Frequency:	**Duration:**
1.	
2.	
3.	
4.	
5.	

Short-Term Goals
1.
2.
3.
4.
5.

Long-Term Goals
1.
2.
3.
4.
5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Harmony Healthcare INTERNATIONAL

Augmentative Evaluation

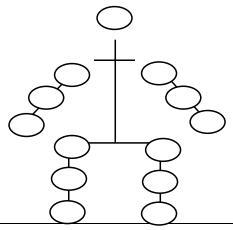
Nursing Rehabilitative/Restorative Care
Nursing Rehabilitation Assessment

I = Independent A = Assist E = Encouragement D = Dependent

		I	A	E	D	
Bed Mobility	Rolling R					Comments/Positioning Needs & Devices
	Rolling L					
	Sit to supine					
	Supine to sit					
Hygiene	Wash hands/face					Comments/Assistive Devices
	Brush teeth					
	Comb hair					
	Shave					
Toileting	Lower Pants					Comments/Assistive Devices
	On/off toilet					
	Perihygiene					
	Raise Pants					
Dressing	Upper body					Comments/Assistive Devices
	Lower body					
	Socks					
	Shoes					
Transfers	Bed to W/C					Comments
	W/C to bed					
	W/C to toilet					
	Toilet to W/C					
W/C Mobility	Propulsion					Comments/Positioning Needs & Devices
	Brakes					
	Manipulation of					
	leg rests					
Dining		I	Set Up	A	D	Comments/Precautions/Assistive Devices
	Breakfast					
	Lunch					
	Dinner					
Gait						
	Device					Comments/Assistive Devices
	Assist					
	Distance					

Resident's Name:_____ Room #:_____Date:_____

Augmentative Evaluation

ROM Limitation No Yes 	Key 1 = Minimal (1/4 range) Limitation 2 = Moderate (1/2 range) Limitation 3 = Severe (3/4 range) Limitation Comments/Positioning/Splinting Needs
Strength UE'S LE'S	Other (i.e., Safety, Judgment, Balance)

Restorative Recommendations

		Treatment Plan	Goals
Ambulation Program			
ROM Program			
Vitality Class			
Grooming Class			
Restorative Dining			

Additional Comments:_____

_____

_____

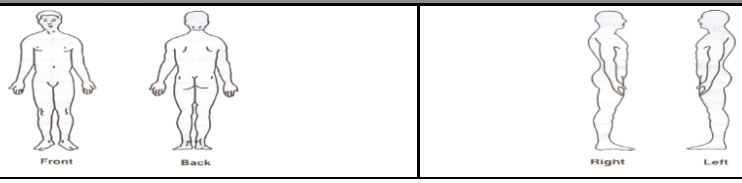
Therapists:_____ _____

Augmentative Evaluation

Wound Evaluation

Patient's Name:	**Facility Name:**
Date of Birth: **Age:**	**Provider Number:**
Diagnoses:	**ICD-10 Codes:**
Admission Date:	**Evaluation date:**
Onset Date:	**Treatment DX:**
Medicare Number:	**Discharge Date:**
Therapist:	**Physician:**
Prior Level of Function:	
Discharge Plan:	
Precautions:	

Wound Locale



Feet

Wound Grading

Stage 1:
Stage 2:
Stage 3:
Stage 4:

Types Of Wounds

1. Diabetic Ulcer	4. Arterial Ulcer	7. Pressure Ulcer	10. Other
2. Laceration	5. Skin Tear	8. Abrasion	
3. Venous Stasis	6. Surgical	9. Burn	

Resident Name – Last	First	Middle	Attending Physician	Chart No.

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Augmentative Evaluation

Wound Evaluation (Continued)

Wound Description

Assessment Areas	Wound 1 Date:	Wound 1 Date:	Wound 2 Date:	Wound 2 Date:	Wound 3 Date:	Wound 3 Date:	Comments
Type							
Location							
Stage							
Length							
Width							
Depth							
Wound Bed							
Tunneling							
Drainage							
Undermining							
Odor							
Pain							
Proximal Skin							

Treatment Plan

Frequency:	Duration:
1.	
2.	
3.	
4.	
5.	

Short-Term Goals	Long-Term Goals
1.	1.
2.	2
3.	3.
4.	4.
5.	5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.

Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Swallowing Evaluation

Patient's Name:		**Facility Name:**	
Date of Birth:	**Age:**	**Provider Number:**	
Diagnoses:		**ICD-10 Codes:**	
Admission Date:		**Evaluation Date:**	
Onset Date:		**Treatment DX:**	
Medicare Number:		**Discharge Date:**	
Therapist:		**Physician:**	
Prior Level of Function:		**Nutritional Status:**	
Discharge Plan:		**Allergies:**	
Precautions:		**Food Preferences:**	
Respiratory Status:		**Dental Status:**	
Self-feeding Level of Assist:		**Most Recent Barium Swallow:**	

Assessment Areas	Severely Impaired	Moderately Impaired	MILDLY Impaired	WFL	Comments
Alertness					
Bite					
Chew					
Cognition					
Coughing/Choking					
Drooling					
Elevation of Hyoid					
Gag Reflex					
Gargly Voice Quality					
Hydration					
Laryngeal Function					
Motivation					
Nasal Regurg.					
Nutrition					
Oral Motor Function					
Oral Motor Structure					
Oral Sensitivity					
Paralysis					
Pocketing					

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Swallowing Evaluation (Continued)

Assessment Areas	Severely Impaired	Moderately Impaired	MILDLY Impaired	WFL	Comments
Positioning					
Reflexive Cough					
Safety					
Struct. Lesion					
Suck					
Volitional Cough					
Weight Loss					

Oral Motor Facial Examination

Assessment Areas	Inadequate	Adequate	Comments
Thin			
Nectar			
Honey			
Pudding			
Puree			
Soft			
Regular			

Treatment Plan

Frequency:	Duration:
1.	
2.	
3.	
4.	
5.	

Short-term goals	Long-term goals
1.	1.
2.	2
3.	3.
4.	4.
5.	5.

Therapist Signature _____ Date _____ / _____ / _____

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.
Physician Signature _____ Date _____ / _____ / _____

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Harmony Healthcare International

Augmentative Evaluation

Lower Level Skills
PT/OT/ST Treatment Checklist

Patient name	Physician	Room	Date	Signatures

Function	Goals Met	Treatment Indicated	Comments
Transfers			
Sample ADLs			
Equipment Needs			
Trunks Control			
Sitting Balance			
Standing Balance			
Bed Positioning/Mobility			
W/C Positioning/Mobility			
RNRP/FMP Established			
Caregiver Training/Education			

Positioning	Goals Met	Treatment Indicated	Comments
Bed: Devices			
Turning/Positioning Schedule			
Wheelchair/Seating			
Equipment Needs			
Referral Seating Clinic			
DME Indicated			
RNRP/FMP Established			
Caregiver Education			

Musculoskeletal	Goals Met	Treatment Indicated	Comments
Tone			
Splint/Inhibitive Casting			
Reflex Assessments			
Inhibition/Facilatory Techniques			
Strength			
Consult MD re: Medications			
Caregiver Education			
Contractures			
UE Splints (Dynamic & Static)			
LE Splints (Dynamic & Static)			
Splint Schedule			
Serial Casting			
RNRP/FMP Established			
Caregiver Education			

Augmentative Evaluation

Lower Level Skills
PT/OT/ST Treatment Checklist (continued)

Feeding	Goals Met	Treatment Indicated	Comments
Hand to Mouth Coordination			
Self-Feeding/Equipment			
Dysphagia			
RNRP/FMP Established			
Caregiver Education			
Sensory stimulation	**Goals met**	**Treatment Indicated**	**Comments**
Auditory			
Visual Tracking			
Vestibular			
Motor Kinesthesia			
Arousal/Attention			
Caregiver Education			
Communication	**Goals Met**	**Treatment Indicated**	**Comments**
Expressive/Receptive			
Augmentative Devices			
Oral Motor Skills			
RNRP/FMP Established			
Caregiver Education			
Cognition	**Goals Met**	**Treatment Indicated**	**Comments**
Orientation			
Memory			
Sequencing			
Distractibility			
Attention/Neglect			
Caregiver Education			
Behavior	**Goals Met**	**Treatment Indicated**	**Comments**
Modification Program			
Caregiver Education			
Cardiopulmonary Conditions	**Goals Met**	**Treatment Indicated**	**Comments**
Position Changes			
Chest P.T.			
Caregiver Education			

Augmentative Evaluation

Higher Level Skills PT/OT/ST Treatment Checklist					
Patient name	**Physician**		**Room**	**Date**	**Signatures**
Dynamic balance	**Goals Met**	**Treatment Indicated**	**Comments**		
Lifting/Carrying Loads					
Accelerated/Decelerate					
Push/Pull					
Reaching					
Reaction Time					
Unilateral Stance					
Ambulation/Physical Terrain	**Goals Met**	**Treatment Indicated**	**Comments**		
Step/Stairs					
Curbs					
Ramps					
Carpets					
Uneven Surfaces					
Grass					
Falls Recovery					
Transfers	**Goals Met**	**Treatment Indicated**	**Comments**		
Tub					
Sofa/Seating					
Floor to Stand					
Kneeling/Squatting					
Varied Height Surfaces					
Car/Van					
Bus/Public Transport					
ADLs	**Goals Met**	**Treatment Indicated**	**Comments**		
Bathing					
Dressing					
Toileting					
Equipment Use/Maintenance					
Don/Doff/Care Prosthesis					

Augmentative Evaluation

Higher Level Skills
PT/OT/ST Treatment Checklist (Continued)

Home Assessment Performance	Goals Met	Treatment Indicated	Comments
Written H.E.P.			
Caregiver education			
Home Evaluation			
Equipment Needs			
Homemaking	**Goals Met**	**Treatment Indicated**	**Comments**
Food Preparation			
Food Clean-up			
Vacuum/Dust/Mop/Sweep			
Laundry			
Appliance Use			
Light Housekeeping			
Occupational Performance	**Goals Met**	**Treatment Indicated**	**Comments**
Energy Conservation			
Work Simplification			
Driving			
Child Care			
Pet Care			
Cognitive Performance	**Goals Met**	**Treatment Indicated**	**Comments**
Phone and Communication Skill			
Mail			
Writing			
Comprehension Medications			
Checking/Bill Paying			
Problem Solving			
Community Access & Safety Issues	**Goals Met**	**Treatment Indicated**	**Comments**
Driving			
Public Transportation			
Shopping/Groceries			
Crossing Streets			
Temperature Assessment			
Emergency Calls			
Hazard Awareness			
Postural Awareness			

Augmentative Evaluation

Home Evaluation

Patient's Name:	**Facility Name:**
Date of Birth: **Age:**	**Provider Number:**
Diagnoses:	**ICD-10 Codes:**
Admission Date:	**Evaluation Date:**
Onset Date:	**Treatment DX:**
Medicare Number:	**Discharge Date:**
Therapist:	**Physician:**
Prior Level of Function:	
Discharge Plan:	
Precautions:	

Dwelling Description

Assessment Areas	Yes	No	Comments
Apartment			
One floor home			
Multiple floor home			
Elevator access			

Entrance Accessibility

Assessment Areas	Front	Back	Side	Comments
Are there stairs to enter?				
Width of stairway at entrance?				
Number of steps?				
Height of steps?				
Is railing present as you go up?				
Is ramp available?				
Is space available for a ramp?				
Width of doorway? (door frame to door frame)				
Clearance of doorway? (the amount of available space in the doorway, accounting for the interference of the door itself)				

Resident Name – Last First Middle	Attending Physician	Chart No.

Augmentative Evaluation

Home Evaluation (Continued)

Bedroom/Sleeping Area			
Assessment Areas	**Yes**	**No**	**Comments**
Can patient enter through doorway?			
Lighting accessible while in bed?			
Flooring risk free?			
Bed transfer accessibility?			
Telephone accessibility while in bed?			

Bathroom			
Assessment Areas	**Yes**	**No**	**Comments**
Can patient enter through doorway?			
Lighting accessible?			
Flooring risk free?			
Toilet transfer accessible?			
Sink functionality?			
Tub transfer accessibility?			
Shower transfer accessibility?			

Kitchen			
Assessment Areas	**Yes**	**No**	**Comments**
Can patient enter through door?			
Lighting accessibility?			
Flooring risk free?			
Kitchen mobility?			
Sink placement?			
Oven/Microwave?			
Controls functional?			

Laundry			
Assessment Areas	**Yes**	**No**	**Comments**
Washer accessible?			
Dryer accessible?			

Other			
Assessment Areas	**Yes**	**No**	**Comments**
Family room accessibility			
Hallways accessibility			

Resident Name – Last First Middle	Attending Physician	Chart No.

Augmentative Evaluation

Home Evaluation (Continued)

Barriers To Independence
1.
2.
3.
4.
5.
6.

Recommendations For Independence
1.
2.
3.
4.
5.
6.

Treatment Plan	
Frequency:	**Duration:**
1.	
2.	
3.	
4.	
5.	

Short-Term Goals	Long-Term Goals
1.	1.
2.	2
3.	3.
4.	4.
5.	5.

Therapist Signature _____ Date ____ / ___ / ___

I have reviewed this Plan of Care and certify a need for the above services for the next thirty days.
Physician Signature _____ Date ____ / ___ / ___

Resident Name – Last	First	Middle	Attending Physician	Chart No.

Augmentative Evaluation

Home Evaluation General Considerations

Entrance to Home
1. Should allow easy entry --- preferably independent entry --- by patient.
2. The condition of the stairs should be noted.
3. The condition and length of the pavement surface leading to the entryway should be noted.
4. If a ramp is necessary, there should be one foot of ramp per one inch of rise.

Furniture Arrangement
1. Should allow sufficient room for maneuvering wheelchair or assistive device.
2. Should provide clear passage from one room to the next.
3. Should allow access to electrical outlets, telephone, and wall switches.
4. Is there any sharp edged furniture that should be relocated?

Bathroom
1. Nonskid adhesive strips should be placed on the floor of the bathtub and/or shower.

Floors
1. All floor coverings should be glued or tacked to the floor.
2. Throw (scatter) rugs should be removed.
3. Nonskid waxes should be used.

Doors
1. Doorways need to be _____ inches wide to allow clearance for wheelchair or assistive device.

Heating Units
1. All radiators, heating vents, and hot water pipes should be appropriately screened off to prevent burns.

Thermostats
1. Is it accessible and located for easy adjustment?

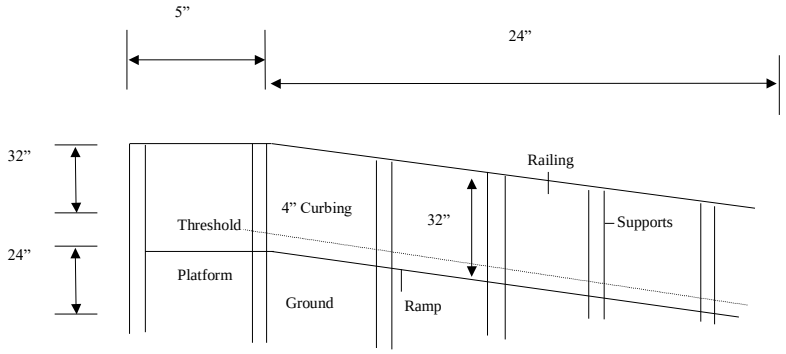
Fire Extinguisher
1. It should be available for easy access.

Cluttered Areas
1. Review and rearrange any areas that act as barriers to walking aides or wheelchairs.

Equipment Present:_____

Augmentative Evaluation

Ramping Guidelines



1. For every inch of rise, there should be 1 foot of ramp. The rise is determined by measuring the height of the steps, including the door threshold (i.e., when total rise is 24 inches, ramp length should be 24 feet).
2. Pressure-treated lumber, marine plywood, or concrete should be used for exterior ramp construction. The ramp/platform should have a non-slip surface (e.g., gritty paper adhesive, nonskid paint, or, if surface is concrete, a broom finish). Ramp footings should be excavated to below the frost line.
3. Door thresholds should have a maximum height of one-half inch.
4. A platform (5 feet by 5 feet) that is level with the door threshold should be constructed immediately outside the doorway with an 18-inch space (minimum) opposite the door swing for wheelchair approach.
5. Ramp surfaces are recommended to be 42 inches wide (minimum) and to extend from level platforms.
6. Bilateral railings should be present and at a maximum height of 32 inches. The ideal width of the railing grip is 1.5 inches. Railings should extend 1 inch beyond the end of the ramp. Ends of railings should be turned down to avoid dangerous projections.
7. A four-inch-high curbing should border the perimeter of the ramp and platform surfaces to prevent wheelchairs from deviating from the path of the ramp.
8. At the ramp bottom, six feet of straight clearance is recommended.
9. Level platforms (5 feet by 5 feet) are required for safety and resting in ramps longer than 30 feet and wherever the ramp surface turns.
10. Overhead coverings for ramped surfaces are suggested.

Program Development

Therapy Referral Guide

Physical Therapy

Alteration in trunk and lower extremity function: pain, stiffness, loss of range of motion, contractures, fractures, tremor, weakness and edema.

Decline in mobility level:

- Bed mobility – increase in staff assistance
- Transfer – increase degree of assistance or more staff members to accomplish
- Wheelchair mobility – decreased ability to maneuver
- Ambulation – increased assistance, decreased endurance, loss of balance, episodes of falling, impaired safety
- Difficulty in positioning
- Identification of State III and Stage IV decubitus ulcers – consult PT prior to obtaining WP orders for clean, superficial Stage III or Stage II ulcers

Occupational Therapy

- Alteration in upper extremity functions related to: pain, stiffness, contractures, fractures, tremor, weakness, loss of ROM, edema.
- Decline on self-care abilities: difficulty following directions, repeating conversations, hostile/angry behavior, combativeness, decreased level of alertness.
- Difficulty with psychosocial/social adjustment: decreased peer/staff interaction, refusing activities, non-acceptance of nursing home placement, denial of physical limitations.
- Decline in self-feeding abilities – restorative feeding.

Speech Therapy

- Left or right CVA's
- Parkinson's Disease
- Multiple Sclerosis
- Dysphagia (swallowing difficulties)
  Decrease in oral intake, difficulty with the initiation of swallow, coughing, choking on food or liquids
- Hearing loss
- Voice disorder
- Decreased cognition: attending, orientation, memory, problem-solving
- Resident does not seem to understand speech or language
- Unintelligible speech or language: inability to express thoughts, needs or feelings

Program Development

Referral Screen Checklist

Please use the checklist below as a guideline for referring patients to Rehab.

1. ### Weight Loss
   _____ More than 5% in the last month
   _____ 5% or less in the last month
   _____ 1 lb. every month
   Other:_____

2. ### Alteration in Self Feeding Skills
   _____ Easily distracted during meal – unable to finish meal
   _____ Difficulty finding utensils
   _____ Can not manipulate fork, spoon, knife
   _____ Does not use utensils given
   _____ Difficulty cutting food with knife or side of fork
   _____ Does not "start" to eat
   _____ Hand to mouth with empty utensil
   _____ Eating food off on side of tray/plate only

3. ### Alteration in Upper Extremity
   _____ Complaining of pain. Specific area:_____
   _____ Having difficulty with one side of body L/R during ADL's
   _____ "Favors" an extremity
   _____ Dropping things (brush, fork, toothbrush)
   _____ "Shaky" hand when using
   _____ Uses two hands during one hand activities
   Other:_____

4. ### Decline in self-care abilities
   _____ Fatigues after dressing only ½ of self
   _____ Can't stand to pull up pants
   _____ Unable to button
   _____ Unable to bring arms overhead to pull on shirt
   Other:_____

5. ### Cognitive deterioration
   _____ Sleeping more frequently during the day
   _____ Answers questions inappropriately
   _____ Needs assistance finding room (was able to find previously)
   _____ Forgets eating meals / refuses stating they have already eaten
   _____ Taking food from others tray
   _____ Disoriented – needs constant reminders about person, place, time

6. Difficulty with Psychological/Social Adjustments
   _____ Isolated/avoids people
   _____ Stays in room
   _____ Crying
   _____ Fighting with roommate/other residents/staff

7. Alteration in trunk and lower extremity function
   _____ Complaining of pain. Specific area:_____
   _____ Favors one extremity L/R
   _____ Limps
   _____ Unable to stand erect
   _____ Missing chair when sitting
   _____ Uses furniture for balance when walking/holds rails in hall
   _____ Swelling of angles
   Other:_____

8. Decline in mobility level
   _____ Change in ability to roll, supine to sit, sitting to supine
   _____ Change in ability to move from point A to point B
   _____ Decreased ability to maneuver wheelchair in room or hallway
   _____ Requires more assistance to walk, needs a device – walker, cane
   _____ Not moving as much

9. Positioning
   _____ Slipping out of chair
   _____ Falls forward
   _____ Leans to one side
   _____ Feet dangle in chair

10. Identification of State III and Stage IV Decubitus Ulcers
    Treatment currently being used:
    Positioning _____
    Type of Bed _____
    Medications _____

11. Dysphagia
    - _____ Food pocketing
    - _____ Choking/coughing
    - _____ Drooling
    - _____ Taking longer time to finish meals

12. Hearing loss
    - _____ Asking you to repeat questions and comments 2x or more
    - _____ Answering questions inappropriately – substitute similar words
    - _____ Not responding when addressed

13. Voice disorder
    - _____ Slurred speech
    - _____ Whispering
    - _____ Voice crackling during speaking

14. Inability to comprehend or express speech or language
    - _____ Jargon sentences that have ½ or no meaning to listener
    - _____ Answers questions inappropriately – ask name and tells you date
    - _____ Struggles to tell staff about problems, needs – bathroom, hunger

Please note any other findings you feel are significant and not covered in the above checklists:

_____

_____

_____

_____

Program Development

Interdisciplinary Resident Screen

Reason for Screen: Admit/Readmit _____ Functional Change Noted _____ Other:_____

Place an X next to the area where the decline has been documented in the medical record.

_____ Decreased ability in gait
_____ Recent falls
_____ Decrease in transfer skills
_____ Change in restraint use
_____ Change in balance
_____ Pressure ulcer
_____ Change in range of motion
_____ Change in bed mobility
_____ Decreased speech intelligibility
_____ Decreased speech comprehension
_____ Change in swallowing
_____ Change in dressing
_____ Change in feeding
_____ Change in toileting
_____ Decrease in UE function
_____ Decrease in skin integrity
_____ Decrease ability to reposition self
_____ Recent weight loss
_____ Change in diet or eating patterns
_____ Change in ability to make needs known
_____ Recent change in memory
_____ Other:

The above changes have been documented in the medical record dated _____.

Signature of Referral Source: _____ Date: _____

The following section to be completed by Rehab

Functional Deficit Area(s):

Comments:

Results of Interdisciplinary Rehab Screen	PT	OT	ST
Therapy evaluation recommended			
No rehab required			
Restorative program requires revision			
Functional Maintenance Program requires revision			
Other:			
Therapist Signature		Date	

Patient Name:	Room #:	Physician:

Physical Therapy Screening Form

Patient: _____ DX: _____ Onset Date: _____

Facility: _____ Therapist: _____

	Date:		
A. Range of Motion			
1. UE – Right – WFL	Y N	Y N	Y N
2. UE – Left – WFL	Y N	Y N	Y N
3. LE – Right – WFL	Y N	Y N	Y N
4. LE – Left – WFL	Y N	Y N	Y N
5. Trunk - WFL	Y N	Y N	Y N
B. Mobility / Transfer			
1. Bed mobility	I A ____	I A ____	I A ____
2. Transfer ability	I A ____	I A ____	I A ____
3. Wheelchair mobility	I A ____	I A ____	I A ____
C. Gait			
1. Device _____	Y N	Y N	Y N
2. Approximate distance	_____ ft	_____ ft	_____ ft
3. Absence of Contractures	Y N	Y N	Y N
4. Ability to follow commands	Y N	Y N	Y N
5. Balance/Static	I A ____	I A ___	I A ___
6. Balance/Dynamic	I A ____	I A ___	I A ___
7. Safety Awareness	I A ____	I A ___	I A ___
D. Skin / Wounds			
1. Any skin problems	Y N	Y N	Y N
Comment _____			
E. Changes in status:			
1. Safety Restraints	Y N	Y N	Y N
2. Physical changes	Y N	Y N	Y N
F. Final Assessment			
Physical Therapy Evaluation	Y N	Y N	Y N
Rescreen	Y N	Y N	Y N
Currently participating in Restorative Nursing	Y N	Y N	Y N
Nursing Services Training	_____ Date	_____ Date	_____Date

Level of Assistance				
SBA	MIN	MOD	MAX	DEP
1	2	3	4	5

Other Information: (Amputation, Limitations, and Physical Deficits/Deformities Limiting Function)

1st Screen: _____

_____

_____

Signature: _____ Date: _____

2nd Screen: _____

_____

_____

Signature: _____ Date: _____

3rd Screen: _____

_____

_____

Signature: _____ Date: _____

Program Development

Occupational Therapy Screening Form

Patient: _____ DX: _____ Onset Date: _____

Facility: _____ Therapist:

Date:			
A. Cognitive / Perceptual Status:			
1. Oriented x3	Y N	Y N	Y N
2. Functional communication	Y N	Y N	Y N
3. Able to follow directions	Y N	Y N	Y N
4. Safely awareness and judgement WFL	Y N	Y N	Y N
5. Visual / Perceptual – 5 minutes	Y N	Y N	Y N
6. Short term memory – 5 minutes	Y N	Y N	Y N
7. Long term memory – long past	Y N	Y N	Y N
8. Recall – past 7 days	Y N	Y N	Y N
B. Range of Motion			
1. Upper extremity – Right – WFL	Y N	Y N	Y N
2. Upper extremity – Left – WFL	Y N	Y N	Y N
3. Trunk control – WFL	Y N	Y N	Y N
4. Absence of contractures	Y N	Y N	Y N
5. Absence of tremors	Y N	Y N	Y N
6. Able to use dominant arm	Y N	Y N	Y N
C. ADL Status:			
1. Bed mobility	I A ____	I A ___	I A ___
2. Transfers	I A ____	I A ___	I A ___
3. Locomotion	I A ____	I A ___	I A ___
4. UE dressing	I A ____	I A ____	I A ____
5. LE dressing	I A ____	I A ____	I A ____
6. Eating	I A ____	I A ____	I A ____
7. Bathing	I A ____	I A ____	I A ____
8. Toileting	I A ____	I A ____	I A ____
9. Personal hygiene	I A ____	I A ____	I A ____
10. Positioning/seating	I A ____	I A ____	I A ____
D. Changes in Status			
1. Safety Restraints	Y N	Y N	Y N
2. Weight Loss	Y N	Y N	Y N
3. Physical changes	Y N	Y N	Y N
4. Need for splinting	Y N	Y N	Y N
E. Final Assessment			
Occupational Therapy Evaluation	Y N	Y N	Y N
Rescreen	Y N	Y N	Y N
Currently participating in Restorative Nursing	Y N	Y N	Y N
Nursing Services Training	_____ Date	_____ Date	_____Date

Level of Assistance				
SBA	MIN	MOD	MAX	DEP
1	2	3	4	5

Other Information: (Amputation, Limitations, and Physical Deficits/Deformities Limiting Function)

1st Screen: _____

_____

Signature: _____ Date: _____

2nd Screen: _____

_____

Signature: _____ Date: _____

3rd Screen: _____

Signature: _____ Date: _____

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-3738
www.harmony-healthcare.com

Program Development

Speech Therapy Screening Form

Patient: _____ DX: _____ Onset Date: _____

Facility: _____ Therapist: | | | |

Date: | | | |

A. Cognitive			
1. Memory: Short Term – 5 minutes	Y N	Y N	Y N
2. Memory: Long Term – long past	Y N	Y N	Y N
3. Follows directions	Y N	Y N	Y N
4. Decision making / Judgement WFL	Y N	Y N	Y N
5. Change in cognitive status (improve or decline)	Y N	Y N	Y N
6. Oriented x3	Y N	Y N	Y N
B. Reading/Writing			
1. Ability to read	Y N	Y N	Y N
2. Ability to comprehend written word	Y N	Y N	Y N
3. Ability to write	Y N	Y N	Y N
4. Visual/Perceptual WFL	Y N	Y N	Y N
C. Communication/Hearing			
1. Hearing WFL	Y N	Y N	Y N
2. Wears hearing aid	Y N	Y N	Y N
3. Has hearing aid and not used	Y N	Y N	Y N
4. Expression mode: speech	Y N	Y N	Y N
5. Expression mode: written message	Y N	Y N	Y N
6. Expression mode: signs/gestures	Y N	Y N	Y N
7. Expression mode: other: _____	Y N	Y N	Y N
8. Makes self understood	Y N	Y N	Y N
9. Speech clarity WFL	Y N	Y N	Y N
10. Ability to understand others	Y N	Y N	Y N
D. Swallowing			
1. Any recent swallowing difficulties	Y N	Y N	Y N
2. Any past swallowing difficulties	Y N	Y N	Y N
3. Any recent choking/coughing	Y N	Y N	Y N
4. Any history choking/coughing	Y N	Y N	Y N
Diet _____ Method _____ i.e. tube, spoon, etc.			
E. Changes in status			
1. Change in resident's ability to express, understand or hear information	Y N	Y N	Y N
2. Weight loss	Y N	Y N	Y N
E. Final Assessment			
Speech Therapy Evaluation	Y N	Y N	Y N
Rescreen	Y N	Y N	Y N
Currently participating in Restorative Nursing	Y N	Y N	Y N
Nursing Services Training	_____ Date	_____ Date	_____ Date

Other Information: (Amputation, Limitations, and Physical Deficits/Deformities Limiting Function)

1st Screen: _____

_____

Signature: _____ Date: _____

2nd Screen: _____

_____

Signature: _____ Date: _____

3rd Screen: _____

Signature: _____ Date: _____

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www.harmony-healthcare.com

Program Development

Physician Certification/Recertification

Part B Rehabilitation

Patient/Resident:_____ HIC Number:_____

Physician:_____

Therapy Discipline:_____ Therapy Start Date:_____

Initial Plan of Treatment: modalities, frequency, intensity and duration:

_____

_____

_____

_____

I certify that I have reviewed and approved the above therapy plan of treatment which is being furnished while the Patient/Resident is under my care and the services are medically necessary.

Certification period: From:_____ Through:_____

Signature of the Attending Physician:_____ Date:_____

Recertification:

No change in above Plan_____

Change in plan as indicated:_____

_____

I recertify that I have reviewed and approved the above therapy plan of treatment which is being furnished while the Patient/Resident is under my care and the services are medically necessary.

Recertification period: From:_____ Through:_____

Signature of the Attending Physician:_____ Date:_____

Recertification:

No change in above Plan_____

Change in plan as indicated:_____

_____

I recertify that I have reviewed and approved the above therapy plan of treatment which is being furnished while the Patient/Resident is under my care and the services are medically necessary.

Recertification period: From:_____ Through:_____

Signature of the Attending Physician:_____ Date:_____

Medicare Appeals and Denials

Medicare Part A Appeals Process

Definition of Appeals

An appeal process is available to providers who are dissatisfied with the determination rendered on their claim. The process consists of five levels. Each level is discussed in detail in below. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. Redetermination, Reconsideration, Administrative Law Judge (ALJ), and Appeals Council requests are applicable to inpatient hospital services and skilled nursing care services. Review and Fair Hearing Appeal requests are applicable to outpatient services.

First Level of Appeal: Redetermination

Providers, suppliers, and beneficiaries that are not satisfied with an initial claim determination may follow the instructions on the Remittance advice or Medicare Summary Notice to request a redetermination of an unfavorable or partially favorable claim decision. Any signed and dated written statement or letter indicating that the beneficiary, his/her authorized representative or provider is expressing dissatisfaction with the initial determination on a claim for skilled nursing care or inpatient services, made to Medicare Part A may constitutes a request for redetermination. A request for a redetermination may be completed using Form CMS-20027. Any requests made not using this form must be submitted in writing and include all of the following specific demographic information related to the claim in question:

1. Beneficiary name;
2. Medicare health insurance claim (HIC) number;
3. The specific service(s) and/or item(s) for which the redetermination is being requested;
4. The specific date(s) of the service; and
5. The name and signature of the party or the representative of the party

Signature Requirements

All appeal requests must be signed by the requestor. Requests received without the appropriate signature are returned. An appeal request submitted with incomplete medical records can result in an unfavorable determination on all or a part of the claim.

Timely Filing:

The time limit for filing a request for redetermination is 120 days from the date of receipt of the Medicare Summary Notice (MSN) or Remittance Advice (RA). The notice of initial determination is presumed to be received 5 days from the date of the notice unless there is evidence to the contrary. The time limit for filing a request for redetermination may be extended in situations the appellant has established good cause. Good cause may be found when the record clearly shows, or the provider, physician or other supplier alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the provider, physician, or other supplier; or,

- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoidable circumstances encompasses situations that are beyond the provider, physician or supplier's control, such as major floods, fires, tornados, and other natural catastrophes

Medical Record Requirements

The redetermination level of the appeal process is performed by Medicare Administrative Contractor (MAC) staff member, who was not involved in making the initial claim determination. How the contractor conducts its redetermination depends on the appellant's request and what is at issue. There may be times where the appellant requests a redetermination of an entire claim and there may be times where he/she requests a redetermination of a specific line item on the claim. The contractor should review all aspects of the claim or line item necessary to respond to the appellant's issue. For example, if the appellant questions the amount paid, the contractor must also review medical necessity, coverage, deductible, and limitation on liability, if applicable. If the appellant requests a redetermination of a specific line item, the contractor reviews all aspects of the claim related to that line item. If appropriate, it reviews the entire claim. If it reviews more than what the appellant indicated, it includes an explanation in the rationale portion of the redetermination letter of why the other service(s)/item(s) were reviewed.

The appellant should submit with the request all medical record documentation that support the medical necessity of the services under appeal. Complete medical records for the dates of service in question may include:

- Itemized statement (detailed listing of all charges) and matching UB92;
- Physician's orders;
- MDS;
- X-ray reports;
- Test results;
- Hospital discharge summary and history and physical
- Medical history;
- Documentation of severity or acute onset;
- Consultation reports;
- Billing forms;
- Referrals;
- Initial evaluation/plan of treatment;
- Nurse's notes;
- Copies of communications between physician and/or beneficiary, hospital,
- Laboratory, etc.;
- Progress notes;
- Medication records;
- Ambulance run sheets;

- Visual fields and photos;
- Therapy records;
- Mammogram reports;
- Operative report;
- Pathology report; and
- Denial letter or remittance advice indicating the denial note.

The file should be organized in a manner that supports an efficient review of the record with pages numbered. The provider may also wish to include a cover letter that summarizes the facts of the case and supports why the initial determination of the claim should be overturned.

Redetermination Decisions:

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request. The results are compiled in a letter and all appropriate parties are notified. Favorable determinations will be reflected on a future remittance advice.

Second Level of Appeal: Reconsiderations

Any party to the redetermination that is dissatisfied with the results may request a reconsideration of decision. The Qualified Independent Contractor (QIC) will conduct the reconsideration. This Reconsideration process allows for an independent review of the initial determination, including the redetermination. This review will likely include a review of the medical necessity issues by a panel of physicians or other healthcare professionals an indicated by the services.

A request for a redetermination may be completed using Form CMS-20033. Any requests made not using this form must be submitted in writing and include all of the following specific demographic information related to the claim in question:

1. Beneficiary name;
2. Medicare health insurance claim (HIC) number;
3. The specific service(s) and/or item(s) for which the redetermination is being requested;
4. The specific date(s) of the service; and
5. The name and signature of the party or the representative of the party
6. The name of the contractor that perform the redetermination

The reconsideration request should also include a clear explanation of the appellant's reason for disputing the redetermination decision. A copy of the RA or Medicare Reconsideration Notice (MRN) and any other pertinent information that supports the request for reconsideration may also be submitted with the reconsideration request. It is not necessary to submit the entire medical record with this request because when the QIC receives a request for reconsideration, it will request the case file from the contractor. Any documentation noted as missing in the redetermination decision must be submitted prior to

the issuance of the reconsideration decision or it will be excluded from consideration at subsequent levels of appeal.

Timely Filing:

The time limit for filing a request for redetermination is 180 days from the date of receipt of the Redetermination decision.

Reconsideration Decisions:

The QIC will render its decision in writing to all parties within 60 days of the receipt of the request for reconsideration. If the QIC is unable to render its decision within 60 days, it will inform the appellant of their right to expedite the case to an ALJ appeal.

Third Level of Appeal: Administrative Law Judge (ALJ)

When a claimant is dissatisfied with a reconsideration decision, the next level of appeal is an Administrative Law Judge hearing. To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration*. The appellant must also send a copy of the request for hearing to the other parties

The request must be made within 60 days from the date the written determination was received. The benefits in question must total $140 or more. The request for an ALJ hearing must be made in writing. For the convenience of parties, HHS provides a form that may be used to request a Medicare ALJ hearing. The contractor provides copies of the form to parties upon request, but there is no requirement that this form be used to make the request. The request must include all of the following:

1. The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed,
2. The name and address of the appellant, when the appellant is not the beneficiary,
3. The name and address of the designated representative, if any,
4. The document control number assigned to the appeal by the QIC, if any,
5. The dates of service,
6. The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed, and
7. A statement of any additional evidence to be submitted and the date it will be submitted.

Hearing preparation procedures are set by the ALJ. The ALJ will determine whether an in person/telephone hearing is warranted on a case by case basis. In some case the appellant may request the decision be made based on the record in the absence of a hearing.

In most cases the ALJ will render a within 90 days although the timeframe may be extended.

Fourth Level of appeal: Appeals Council Review

When the dissatisfaction continues after the ALJ's decision, the claimant may request the Appeals Council (AC) to review the decision. The request must be filed within sixty days of the date of the ALJ decision. If a party requests the Appeals Council to review an ALJ's decision, the Appeals Council may review the decision and adopt, modify, or reverse the ALJ's decision, or remand the case to an ALJ for further proceedings.

In general, the Appeals Council will issue its decision with 90 days of the receipt of the request for review.

Fifth Level of Appeal: Judicial Review in U.S. District Court

Following issuance of a decision by the DAB, a party may request court review of the DAB's decision. A contractor cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court within 60 days of the receipt of the Appeals Council's decision. If a party files a request for court review with a contractor, the contractor must instruct the appellant to re-file with the U.S. District Court. The amount remaining in controversy for requests made before January 1, 2013 is $1,400. The amount remaining in controversy is increased annually by he percentage increase in the medical care component

Appointment of Representative

A party to a hearing may appoint an attorney or other individual to act as his/her authorized representative, unless prohibited by law.

A properly completed Appointment of Representative form (CMS – 1696) is required if:

- the individual (including an attorney) wishes to act as a claimant's representative in a hearing or further level of appeal; or,
- in the case of PRO determination, the beneficiary must execute a form CMS – 1696 The form CMS – 1696 can be obtained through the local Social Security Office.

When accepting an appeal request from an appointed representative, the representative form (1696) will be accepted. However, except in the above two examples, a representative can also be appointed by submission of a written statement containing:

- the beneficiary's name, address, telephone number and signature;
- the representative's name, address, telephone number and signature;
- a dated statement indicating that the beneficiary authorized the representative to act on his/her behalf for the claim in question; and,
- a statement that the representative accepts the appointment (plus appropriate waivers of payment and fees if the representative is the physician/supplier or provider who provided the services at issue on appeal).

As the representative, you may exercise any and all rights given to parties on behalf of the person you are representing. You will be notified of any action, request for documentation and claim determination.

Beneficiary Deceased

If the beneficiary is deceased, an appeal request may be filed by the legal representative of the estate. In the absence of a legal representative, the appeal request may be filed by any person who has assumed responsibility for settling the decedent's estate.

Reopenings

A reopening is not an appeal. It is a discretionary action by Medicare if good cause exists.

A reopening of an initial claim determination only can take place when all appeal rights have been exhausted or after the time limit for an appeal has expired.

Reopenings are conducted when:

- New and significant material evidence, which was not available when the initial decision was made, is presented;
- Medicare clerical or computational errors were made;
- Errors are identified based on the evidence; or,
- Errors were caused by fraud.

Reopenings can also be made between the review and fair hearing process when:

- Information is submitted supporting a full reversal;
- On Medicare's initiative it is determined that a claim was erroneously paid;
- If it is determined that an entire group of claims were denied because of a systems error or malfunction; or,
- An incorrect interpretation of Medicare law, policy or regulations.

Medicare Fee-For-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Monetary Threshold to be Met
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (AJL) Hearing	60 days from the date of receipt of the reconsideration	At least $140 remains in controversy
4. Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of DAB decision or declination of review by DAB.	At least $1400 remains in controversy.*

* Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Where to File an Appeal

Level	Where to File an Appeal	
	Part A*	Part B
Redetermination	FI or MAC	Carrier
Reconsideration	QIC	QIC
ALJ Hearing	MAC or HHS OMHA Field Office if heard by a QIC	Carrier or HSS OMHA Field Office if heard by a QIC
DAB Review	DAB or ALJ Hearing Office	DAB or ALJ Hearing Office

* Includes part B claims filed with the MAC.

Help Letter Review Check List

Period Skilled Nursing Chart Review: From: _____ To: _____

Medicare Admission Date: _____ Diagnosis:

_____

MDS Reference Dates Review

	5 day	14 day	30 day	60 day	90 day	SOT/EOT OMRA
ARD						
Billing Dates						
RUG/HIPPS						

	COT	COT	COT	COT	COT	COT
ARD						
Billing Dates						
RUG/HIPPS						

ICD-9 Codes

_____

_____

_____

_____

MDS Forms Completed Since Admission (MAC may only request for billed period)

- ❑ MDSs that cover days billed
- ❑ ARDs set in acceptable time frames
- ❑ Signed by all disciplines
- ❑ Interviews are signed on day interview completed
- ❑ Signed by RN Coordinator
- ❑ Documentation to support Rehabilitation RUG in Section O
- ❑ Documentation to support coding IVs in Section K & O (from hospital if applicable)
- ❑ Documentation to support ADL coding in Section G
- ❑ RUG rate matches billed rate on UB-04
- ❑ Z0500B within 14 days of ARD
- ❑ OMRAs completed when necessary and within appropriate time frames
- ❑ Interviews completed, not dash-filled
- ❑ Documentation present to support diagnoses coded in Section I
- ❑ Documentation present to support Shortness of Breath in Section J

Physician Certification

- ❑ Signed on admit
- ❑ Recertification signed by day 14 and every 30 days after for entire billing period
- ❑ Details regarding skilled Nursing services present
- ❑ Details regarding skilled Therapy services present

Physician Orders for Review Period

- ❑ Monthly orders signed by physician
- ❑ Interim orders signed by physician
- ❑ Telephone orders signed by physician
- ❑ Therapy evaluation orders present and signed
- ❑ Therapy clarification orders present and signed
- ❑ Therapy recertifications present and signed

Acute Discharge Summary/ Acute and Facility History and Physical

- ❑ Three day qualifying stay verified
- ❑ Discharge Summary
- ❑ Hospital and Facility H&P

Physician Progress Notes

- ❑ Admission note
- ❑ MD progress note at least every 30 days

Nursing Notes

- ❑ Admission note
- ❑ Daily skilled Nursing notes present for entire period under review
- ❑ Daily skilled Nursing notes present for MDS look-back periods
- ❑ Daily notes 30 days prior to ARD date of any MDS billed
- ❑ Documentation to support daily skills listed on MD Certification
- ❑ Weekly Medicare meeting summaries
- ❑ Documentation to support staff coding of PHQ-9-OV

Medication/ Treatment Records

- ❑ MARs present for MDS look-back periods
- ❑ TARs present for MDS look-back periods
- ❑ Minutes on Respiratory Therapy and or nursing treatment sheets match each MDS in billing period

- ❑ Wound flowsheets completed in full and present for each MDS in billing period

Parenteral/ Enteral Intake Records to Support Amount Received

- ❑ Dietician notes for G/J Tube
- ❑ Treatment or Medication Records
- ❑ Input and Output if applicable

ADL Flowsheets

- ❑ Flowsheets present for all MDS look-back periods
- ❑ All dates have been filled in
- ❑ All signatures present
- ❑ Corrections included

Rehabilitation - For Review Period and 7 days prior to ARD of any MDS billed.

- ❑ Evaluation signed timely by physician (always include initial evaluation with all review periods) for each discipline provided in ARD and Review period
- ❑ Updated Monthly Progress Note for each discipline provided in ARD and Review period
- ❑ Weekly Progress Notes present and support ongoing skilled services (present for entire period in Review)
- ❑ Billing logs for entire period in review
- ❑ Billing logs for ARD look-back periods
- ❑ Minutes and days on therapy logs match Section O
- ❑ Daily documentation supports minutes on billing logs
- ❑ Daily Notes for each discipline provided in ARD and Review period
- ❑ Daily Notes support clinically justification for co-treatment
- ❑ Co-treatment minutes supported by both disciplines
- ❑ Co-treatment minutes on billing logs, Daily Notes, and Section all match
- ❑ Any additional documentation to support functional progress (standardized testing, etc.)

Restorative Nursing Documentation

- ❑ Plan of care
- ❑ Daily log
- ❑ Progress notes at least every 30 days
- ❑ Physician orders

Diagnostic Reports (labs, x-ray)

- ❑ Include for review period

Trach and Vent Documentation

- ❑ Documentation to support trach care

Other documents to support skilled level of care (review billed RUG and include only if needed to support skill/RUG billed).

- ❑ BEHAVIOR: Behavior sheets, Social Service Notes and Psych Documentation
- ❑ Reduce Physical Functioning: Dietary, possibly detailed care plan to support aggregate of services
- ❑ Nursing teaching sheets to family and patient
- ❑ Consult reports

Denial Notification if remained in facility and Medicare discontinued at end of review period

- ❑ Signed by patient or guardian
- ❑ Check to have Medicare review or decline review

Signature Log

- ❑ Signature Log included for all staff members

The following items must be added to this record prior to submitting:

1. 5.
2. 6.
3. 7.
4. 8.

Comments/Risk Areas:

_____

_____

_____

DON: _____ MDSC:_____ Rehab:_____ Regional/Consultant : _____

Part B Help Letter Check List

Resident Name:_____
Period Skilled Nursing Chart Review: From: _____ To: _____
Discipline: PT OT ST Reason for Referral:_____

UB-04 Diagnosis:_____

Billed Services:

HCPCS	Total Units	$	Dates Billed

CAP date: PT/ST_____ OT_____

Physician Certification

- ❑ Plan of Treatment Signed.

Physician Orders for Review Period

- ❑ Monthly orders signed by physician
- ❑ Interim orders signed by physician
- ❑ Telephone orders signed by physician
- ❑ Therapy evaluation order
- ❑ Therapy order for entire treatment period

Therapy - For Review Period

- ❑ Evaluation (700) signed timely by physician (always include initial evaluation with all review periods)
- ❑ PLOF stated reflects decline
- ❑ Updated monthly plan (701), every 30 days, signed by physician for reviewed period
- ❑ Progress filled in at bottom of 700s and 701s to support skill
- ❑ Progress note for entire billing period that supports skilled level of care (every 10th treatment).
- ❑ Documentation reflects progress towards goals

Part B Help Letter Check List (continued)

Therapy logs

- ❑ All completed billing logs for treatments that were billed during the period
- ❑ Minutes and days on therapy logs match treatment record
- ❑ Daily documentation of minutes on log or in record
- ❑ HCPCS codes billed supported by daily note
- ❑ 59 modifier used for mutually exclusive codes
- ❑ KX modifier used for treatment above the cap

Physician Progress Notes

- ❑ Related to therapy

Nurses Notes

- ❑ Related to referral for therapy
- ❑ Related to deficits being treated for in therapy
- ❑ Related to improvement for deficits being treated
- ❑ Skin documentation for positioning

Diagnostic Reports (labs, x-ray)

- ❑ Include for review period

The following items must be added to this record prior to submitting:

1. 5.
2. 6.
3. 7.
4. 8.

Comments:

_____
_____
_____
_____

DON: _____ MDSC:_____ Rehab:_____ Regional/Consultant : _____

Part B Help Letter Check List (continued)

Therapy Services Summary:

Attached please find the requested records to support Part B therapy services provided by _____(facility):

Patient Name: _____
HIC#:_____
Physical Therapy Occupational Therapy Speech Therapy
Dates of Service:_____

_____

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2711	Date: May 24, 2013
Change Request 7903	

Subject: Expedited Determinations for Provider Service Terminations

I. Summary Of Changes: This change request provides new information to the the manual in accordance with CMS-4004-FC (69 FR 69252, November 26, 2004), effective July 1, 2005. The manual addition ensures consistency with provisions of the final rule and clarifies operating instructions.

Effective Date: August 26, 2013

Implementation Date: August 26, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. Changes In Manual Instructions: (N/A if manual is not updated)

R=Revised, N=New, D=Deleted-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30 / Table of Contents
N	30/260/260.1/Statutory Authority
N	30/260/260.2/Scope
N	30/260/260.2.1/Exceptions
N	30/260/260.3/Notice of Medicare Non-Coverage
N	30/260/260.3.1/Alterations to the NOMNC
N	30/260/260.3.2/Completing the NOMNC
N	30/260/260.3.3/Provider Delivery of the NOMNC
N	30/260/260.3.4/Required Delivery Timeframes
N	30/260/260.3.5/Refusal to Sign the NOMNC
N	30/260/260.3.6/Financial Liability for Failure to Deliver a Valid NOMNC
N	30/260/260.3.7/Amending the Date of the NOMNC
N	30/260/260.3.8/NOMNC Delivery to Representatives
N	30/260/260.3.9/Notice Retention for the NOMNC
N	30/260/260.3.10/Hours of NOMNC Delivery
N	30/260/260.4/Expedited Determination Process
N	30/260/260.4.1/Beneficiary Responsibilities
N	30/260/260.4.1.1/Timeframe for Requesting an Expedited Determination
N	30/260/260.4.1.2/Provide Information to QIO
N	30/260/260.4.1.3/Obtain Physician Certification of Risk (Home Health and CORF services only)
N	30/260/260.4.2/Beneficiary Liability During QIO Review
N	30/260/260.4.3/Untimely Requests for Review
N	30/260/260.4.4/Provider Responsibilities
N	30/260/260.4.5/The Detailed Explanation of Non-Coverage
N	30/260/260.5/QIO Responsibilities
N	30/260/260.5.1/Receive Beneficiary Requests for Expedited Review
N	30/260/260.5.2/Notify Providers and Allow Explanation of Why Covered Services Should End
N	30/260/260.5.3/Validate Delivery of the NOMNC
N	30/260/260.5.4/Solicit the Views of the Beneficiary
N	30/260/260.5.5/Solicit the Views of the Provider

III. Funding: for fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC

statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. Attachments:

Business Requirements Manual Instruction

*Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2711	Date: May 24, 2013	Change Request: 79

Subject: Expedited Determinations for Provider Service Terminations

Effective Date: August 26, 2013

Implementation Date: August 26, 2013

I. General Information

A. Background: This change request provides new information to the manual in accordance with the 42 Code of Federal Regulations (CFR), Part 405 Medicare Program, Expedited Determination Procedures for Provider Service Terminations: Final Rule (Final Rule), published November 26, 2004. The manual addition ensures consistency with provisions of the final rule and clarifies operating instructions.

B. Policy: Under the procedures listed in 42 CFR Part 405 Subpart J, Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106 554), Medicare beneficiaries can appeal their provider service terminations to a Quality Improvement Organization (QIO).

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2004 (MMA).

II. Business Requirements Table

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility												
		A/B MAC			D M E	F	C	R	Shared-System Maintainers				Other
		A	B	H					F	M	V	C	

7903.1	Contractors shall be aware of the new policy in chapter 30, sections 260 through 261.												Providers

III. Provider Education Table

Number	Requirement	Responsibility

		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
7903.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			X	X	X	

IV. Supporting Information

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. Contacts

Pre-Implementation Contact(s): Janet Miller, 404-562-1799 or janet.miller@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. Funding

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections
Table of Contents

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260 – Expedited Determinations of Provider Service Terminations
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.1 –Statutory Authority
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Section 1869(b)(1)(F) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554) granted beneficiaries in Original Medicare the right to an expedited determination process to dispute the end of their Medicare covered care in certain provider settings.
This process was implemented though a final rule with comment period, CMS-4004-FC (69 FR 69252, November 26, 2004), effective July 1, 2005. The resulting regulations are located at 42 CFR Part 405, §§405.1200 - 405.1204. There is a parallel process for beneficiaries enrolled in Medicare health plans. (See §§90.2-90.8 in Chapter 13 of the Medicare Managed Care Manual (CMS Pub. 100-16)

260.2 – Scope
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end: For purposes of this instruction, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy). A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B. A NOMNC must be delivered by the SNF when both Part B therapies are ending.

Skilled Nursing Facilities includes beneficiaries receiving Part A and B services in Swing Beds.

260.2.1 – Exceptions
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).
- When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
- When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).
- When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).
- When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).
- When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).
- When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

260.3 – Notice of Medicare Non-Coverage
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The notice is subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the NOMNC. The notice and accompanying instructions may be found online at http://www.cms.gov/Medicare/Medicare-General-Information/BNI

260.3.1 - Alterations to the NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages, but must not be condensed to one page.
Providers may include their business logo and contact information on the top of the NOMNC. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, etc.
Providers may include information in the optional "Additional Information" section relevant to the beneficiary's situation.

Note: Including information normally included in the Detailed Explanation of Non-Coverage (DENC) in the "Additional Information" section does not satisfy a provider's responsibility to deliver the DENC, if otherwise required.

260.3.2 - Completing the NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Providers must use the OMB-approved NOMNC (CMS-10123). Providers must type or write the following information in the corresponding blanks of the NOMNC:

- Patient name
- Medicare patient number
- Type of coverage (SNF, Home Health, CORF, or Hospice)
- Effective date (last day of coverage)

Note: The effective date is always the last day beneficiaries will receive coverage for their services. Beneficiaries have no liability for services received on this date, but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services. Because SNFs cannot bill the beneficiary for services furnished on the day of (but before the actual moment of) discharge, beneficiaries may leave a SNF the day after the effective date and not face liability for such services.

260.3.3 – Provider Delivery of the NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per §260.2. A NOMNC must be delivered even if the beneficiary agrees with the termination of services.

Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of notice delivery.

260.3.4 –Required Delivery Timeframes

(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. For example, if the last day of covered SNF care is a Friday, the NOMNC should be delivered no later than the preceding Wednesday.

Note: The two day advance requirement is NOT a 48 hour requirement. For example, if a patient's last covered home health service is at 10AM on Wednesday and the notice is delivered at 4PM on the prior Monday, it is considered timely.

If home health services are being provided less frequently than daily, the notice must be delivered no later than the next to last visit before Medicare covered services end. For example, if home health care is provided on Tuesdays and Thursdays, and Tuesday is the last day of Medicare covered services, the notice must be delivered no later than the preceding Thursday.

The NOMNC may be delivered earlier than two days preceding the end of covered services. However, delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination.

The notice may not be routinely given at the time services begin. An exception is when the services are expected to last fewer than two days. In these instances, the notice may be given by the provider when services begin.

There is an accepted circumstance when the NOMNC may be delivered sooner than two days or the next to last visit before coverage ends. This exception is limited to cases where a beneficiary receiving home health services is found to no longer be homebound, and thus ineligible for covered home health care. In this circumstance, the NOMNC should be immediately delivered to the beneficiary upon discovery of the loss of homebound status. We expect that in the vast majority of cases, in all settings, the decision of a physician to end care will be based on medical necessity, and thus, foreseeable by the provider within the required time frames for notice delivery.

260.3.5 - Refusal to Sign the NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the beneficiary refuses to sign the NOMNC the provider should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the NOMNC remain entitled to an expedited determination.

260.3.6 - Financial Liability for Failure to Deliver a Valid NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If a Qualified Independent Contractor (QIO) determines that a provider did not deliver a valid NOMNC to a beneficiary, the provider is financially liable for continued services until

two days after the beneficiary receives valid notice, or until the effective date of the valid notice, whichever is later.

260.3.7 - Amending the Date of the NOMNC (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the initial NOMNC was delivered to a beneficiary and the effective date was changed, the provider may amend the notice to reflect the new date. The newer effective date may not be earlier than the effective date of the original notice except in those cases involving the abrupt end of services, as discussed in §260.3.4.
The beneficiary must be verbally notified as soon as possible after the provider is aware of the change. The amended NOMNC must be delivered or mailed to the beneficiary and a copy retained in the beneficiary's file.
If an expedited determination is already in progress, the provider must immediately notify the QIO of the change and provide an amended notice to the QIO.

260.3.8 – NOMNC Delivery to Representatives (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC may be delivered to a beneficiary's appointed or authorized representative. Appointed representatives are individuals designated by beneficiaries to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696.
http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf See Chapter 29 of the Medicare claims processing manual, section 270.1, for more information on appointed representatives.

CMS usually requires that notification to a beneficiary who has been deemed legally incompetent be made to an authorized representative of the beneficiary. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

However, if a beneficiary is temporarily incapacitated a person (typically, a family member or close friend) whom the provider has determined could reasonable represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the notices described in this section. Such a representative should have the beneficiary's best interests at heart and must act in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.
In these instances of delivering a notice to an unnamed representative, the provider should annotate the NOMNC with the name of the staff person initiating the contact, the name of

the person contacted, and the date, time, and method (in person or telephone) of the contact. A copy of the NOMNC with this information should be retained in the beneficiary's record.

Note - Exceptions to in person notice delivery. If the NOMNC must be delivered to a representative not living with the beneficiary, the provider is not required to make off-site in- person notice delivery to the representative. The provider must complete the NOMNC as required and telephone the representative at least two days prior to the end of covered services. The provider should inform the representative of the beneficiary's right to appeal a coverage termination decision.
The information provided should include the following:

- The beneficiary's last day of covered services, and the date when the beneficiary's liability is expected to begin.
- The beneficiary's right to appeal a coverage termination decision.
- A description of how to request an appeal by a QIO.
- The deadline to request a review as well as what to do if the deadline is missed.
- The telephone number of the QIO to request the appeal.

The date the provider communicates this information to the representative, whether by telephone or in writing, is considered the receipt date of the NOMNC.
The NOMNC must be annotated with the following information on the day that the provider makes telephone contact:
Reflect that all of the information indicated above was communicated to the representative;
Note the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.
A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the beneficiary's medical file.
If the provider chooses to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS)
The burden is on the provider to demonstrate that timely contact was attempted with the representative and that the notice was delivered.
The date that someone at the representative's address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary's medical file.
If both the provider and the representative agree, providers may send the notice by fax or e-mail, however, providers fax and e-mail systems must meet the The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

260.3.9 - Notice Retention for the NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The provider must retain the original signed NOMNC in the beneficiary's file. The beneficiary should receive a paper copy of the NOMNC that includes all of the required information such as the effective date and covered service at issue. Electronic notice retention is permitted if the NOMNC was delivered electronically.

260. 3.10 - Hours of NOMNC Delivery
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Notice delivery should occur within the normal operating hours of the provider. Providers are not expected to extend their hours or days of business solely to meet the requirements of the expedited determination process. However, it is expected that all notices be provided as timely as possible within these constraints.

260.4 - Expedited Determination Process
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.4.1 – Beneficiary Responsibilities
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.4.1.1—Timeframe for Requesting an Expedited Determination
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A beneficiary who receives a NOMNC and disagrees with the termination of services may request an expedited determination by the appropriate QIO for the state where the services were provided. The beneficiary must contact the QIO by noon of the day before the effective date on the NOMNC. The beneficiary may contact the QIO by telephone or in writing. If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available.

260.4.1.2– Provide Information to QIO
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The beneficiary must be available to answer questions or supply information requested by the QIO. The beneficiary may, but is not required to, supply additional information to the QIO that he or she believes is pertinent to the case.

260.4.1.3 – Obtain Physician Certification of Risk (Home Health and CORF services only)
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A beneficiary must obtain a physician certification stating that failure to continue home health or CORF services is likely to place the beneficiary's health at significant risk. Without such a certification statement a QIO may not make a determination for service terminations in these settings.
The physician certification is a written statement from any licensed physician contacted by a beneficiary. This is a special certification required only in this expedited determination process for expedited determinations in home health and CORF settings.
A beneficiary may request an expedited determination from a QIO before obtaining this certification of risk. Once the QIO is aware of a review request, it will instruct the beneficiary on how to obtain the necessary certification from a physician.

260.4.2 – Beneficiary Liability During QIO Review
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A provider may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process, including a reconsideration by a Qualified Independent Contractor (QIC), if applicable, is complete.

260.4.3 - Untimely Requests for Review
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the beneficiary makes an untimely request to the QIO, the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline. The QIO will make a determination as soon as possible upon receipt of the request.
Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request.
The coverage protections discussed in 260.4.2 do not apply to a beneficiary who makes an untimely request to the QIO.

260.4.4 - Provider Responsibilities
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

When a provider is notified by a QIO of a beneficiary request for an expedited determination, the provider must--

• Deliver the beneficiary a DENC (see §260.4.5) by close of business the day they are notified;
• Supply the QIO with copies of the NOMNC and DENCs by close of business of the day of the QIO notification;
• Supply all information, including medical records, requested by the QIO. The QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record; and
• Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the QIO. The provider may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.

260.4.5 - The Detailed Explanation of Non-Coverage (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The DENC is subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the DENC. The notice and accompanying instructions may be found online at http://www.cms.gov/Medicare/Medicare-General-Information/BNI Medicare providers are responsible for the delivery of the DENC to beneficiaries who request an expedited determination by the QIO.
The DENC must contain the following information:
• The facts specific to the beneficiary's discharge and provider's determination that coverage should end.
• A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered.
• A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

The provider should make insertions on the notice in Spanish, if necessary. If this is impossible, additional steps should be taken to ensure that the beneficiary comprehends the content of the notice. Providers may resource CMS multilingual services provided through the 1-800-MEDICARE help line if needed.
The delivery must occur in person by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. A provider may also choose to deliver the DENC with the NOMNC.
The DENC does not require a signature but should be annotated in the event of a beneficiary's refusal to accept the notice upon delivery.

Note: An HHA is not required to make a separate trip to the beneficiary's residence solely to deliver a DENC. Upon notification from the QIO of a beneficiary's request for an expedited determination, an HHA may telephone the beneficiary to provide the information contained on the DENC, annotate the DENC with the date and time of telephone contact and file with the beneficiary's records. A hard copy of the DENC should be sent to the beneficiary via tracked mail or other personal courier method by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The burden is on the provider to demonstrate that timely contact was attempted with the beneficiary and that the notice was delivered.

DENC delivery to representatives, DENC hours of delivery, and DENC retention requirements are the same as the NOMNC requirements outlined in §260.3.

Expedited Determination Scenario in a Skilled Nursing Facility - Example

On June 2nd, the SNF delivers a NOMNC to Bob Mills notifying him that his Medicare covered stay will end on June 4th. Bob decides to request an expedited determination.

June 2nd	June 3nd	June 4th	June 5th	June 6th
NOMNC Delivered Bob receives a NOMNC indicating that his coverage is ending June 4th.	**Bob must** request an expedited determination by noon today.	**NOMNC Effective Date** This is the last day of coverage, as stated on the NOMNC.	**If Bob made his request on June 2nd:** The QIO makes its decision and notifies Bob and the SNF by COB.	**If Bob made his request on June 3rd:** The QIO makes its decision and notifies Bob and the SNF by COB.
	The QIO must notify the SNF of Bob's request for an expedited determination. **The SNF must deliver the DENC to Bob by COB today.** **The SNF must provide relevant medical records to the QIO by COB today.**	**The beneficiary has no liability for this day as this is the last day of coverage in the SNF.**	**If QIO decision is unfavorable:** Beginning today Bob is liable for his stay if he does not leave the SNF.	

260.5 – QIO Responsibilities
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.5.1 - Receive Beneficiary Requests for Expedited Review
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

QIOs must be available to receive beneficiary requests for review 24 hours a day, 7 days a week.

260.5.2 - Notify Providers and Allow Explanation of Why Covered Services Should End
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

When the QIO receives a request from a beneficiary, the QIO must immediately notify the provider of services that a request for an expedited determination was made. If the request is received after normal working hours, the QIO should notify the provider as soon as possible on the morning after the request was made.

260.5.3 –Validate Delivery of NOMNC
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must validate that the NOMNC included the required elements outlined below:

- Date that coverage of services ends.
- Date that beneficiary's financial liability begins.
- Description of right to an expedited determination (and how to request an expedited determination) and the right to submit relevant information to the QIO.
- Right to detailed information on why the provider believes Medicare will no longer cover services.
- Contact information for QIO in the state where services were delivered.

The QIO should determine that NOMNC delivery was valid if all of the following criteria are met:

- All elements stated above are included.
- The beneficiary signed and dated the notice. If the NOMNC was annotated because the beneficiary refused to sign the notice upon delivery, the QIO may still conduct an expedited determination in these instances
- Notice was delivered at least two days before services terminate. For a non-residential provider, the notice may be delivered at the next to last visit before services terminate.

Invalidating a NOMNC should be a rare occurrence. The only reasons to invalidate are the lack of one of the criteria stated above or a pattern of minor errors as established by the provider.

If a QIO invalidates a NOMNC, a new NOMNC must be issued to the beneficiary with an effective date at least two days after the beneficiary receives valid notice. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

260.5.4 - Solicit the Views of the Beneficiary (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must solicit the views of the beneficiary who requested the expedited determination.

260.5.5 - Solicit the Views of the Provider Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must afford the provider an opportunity to explain why the discharge is appropriate.

260.5.6 – Make Determination and Notify Required Parties Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

No later than 72 hours after receipt of the request for an expedited determination, the QIO must make its determination on whether the discharge is appropriate based on medical necessity or other Medicare coverage policies.

Note: If the QIO does not receive supporting information from the provider, it may make its determination based on the evidence at hand, or defer a decision until it receives the necessary information. If this delay results in continued services for the beneficiary, the provider may be held financially liable for these services as determined by the QIO.

The QIO must notify the beneficiary, the beneficiary's physician, and the provider of services of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability. QIOs must also inform the beneficiary of the right to an expedited reconsideration by the Qualified Independent Contractor (QIC) and how to request a timely expedited reconsideration. The QIO will make its initial notification via telephone and will follow up with a written determination letter.

260.6 - Effect of a QIO Expedited Determination (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO determination is binding unless the beneficiary pursues an expedited reconsideration per section 270 of this chapter.

260.6.1 - Right to Pursue an Expedited Reconsideration (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If dissatisfied with the expedited determination, the beneficiary may request an expedited reconsideration according to the procedures described in section 270 of this chapter.

260.6.2 - Effect of QIO Determination on Continuation of Care (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the QIO decision extends coverage to a period where a physician's orders do not exist, either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care, providers cannot deliver care. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.

If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered if that care is later terminated, per the requirements of this section. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

The QIO decision will affect the necessity of subsequent Advance Beneficiary Notice of Noncoverage (ABN) deliveries.

Example: If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuance of Home Health Advanced Beneficiary Notices (HHABNs) as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA, even though Medicare will not pay, an HHABN with Option Box 1 must be issued to the beneficiary since this would be an initiation of non-covered care.

Example: If covered Skilled Nursing Facility (SNF) care continues following a favorable QIO decision for the beneficiary but later ends due to the end of Medicare coverage, and the patient wishes to continue receiving uncovered care at the SNF, a SNFABN must be issued to the beneficiary.

260.6.3 - Right to Pursue the Standard Claims Appeal Process (Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If a beneficiary receives services of the type at issue in the expedited determination after the coverage end date, and coverage is denied, the beneficiary may appeal the denial within the standard claims appeal process (See Chapter 29 of this manual.)

261 – Expedited Determination Notice Association with Advance Beneficiary Notices
(Rev.2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice delivery must be determined by the individual NOMNC requirements per this section and ABN delivery requirements per §1879 of the Act and per guidance in this chapter. Both the NOMNC and an ABN may be required in certain instances.

Only one notice may be required when Medicare covered care is ending.

Example: A beneficiary is receiving CORF services and all covered CORF care is ending. A NOMNC must be delivered at least two days, or two visits, prior to the end of coverage. If the beneficiary does not continue the CORF services, an ABN should not be issued.

Some situations may require two notices at the end of Medicare covered care.

Example: A beneficiary's Part A stay is ending because skilled level care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial care. The beneficiary must receive the NOMNC two days prior to the end of coverage. A SNFABN must also be delivered before custodial care begins.

It is also possible that no notice is required when Medicare coverage is ending.

Example: A beneficiary exhausts the 100 day benefit in a SNF. In this instance, the NOMNC should not be delivered. The SNFABN is not required in this situation. However, it can be issued voluntarily, as a courtesy to the beneficiary.

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

Table of Contents
(Rev. 3698, 01-27-17)

Transmittals for Chapter 30

10 - Financial Liability Protections (FLP) Provisions of Title XVIII (Rev. 1, 10-01-03)

The financial liability protections (FLP) provisions of the Social Security Act (the Act) protect beneficiaries and health care providers (physicians, practitioners, suppliers, and providers) under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. The FLP provisions include:

- Limitation On Liability (LOL) under §1879(a)-(g) of the Act.
- Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l) of the Act.
- Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical
- Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act.

The FLP provisions apply to individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B), but are not applicable to Medicare M+C (Part C) enrollees nor to non-Medicare enrollees. The Advance Beneficiary Notices (ABNs) proper to the FLP provisions are to be used solely for individuals enrolled in the Medicare FFS program and are not to be used for Medicare M+C enrollees nor for non-Medicare enrollees.

The FLP provisions apply very specifically, on the basis of the statutory provision under which a particular denial occurs as well as other criteria described in this Chapter 30. The manner in which the FLP provisions apply varies by whether or not the claim is assigned or non-assigned, under Part A or Part B, and the statutory basis for denial of the claim. Following are frequently asked questions (FAQs) about differences between the Limitation On Liability and Refund Requirements provisions. More specific guidance follows later in this Chapter.

Q.1. What are the main differences between “Limitation On Liability” (LOL) and the “Refund Requirements” (RR)?

A.1. LOL and RR are both financial liability provisions of the Medicare law. LOL is provided

under §1879(a)-(g) of the Act for all Part A services and all assigned claims for Part B services. RR is provided under §1879(h) of the Act for assigned claims for medical equipment and supplies. RR is also provided for unassigned claims for medical equipment and supplies under §§1834(a)(18) and 1834(j)(4) of the Act and for unassigned claims for physicians' services under §1842(l) of the Act. LOL provides for program payment for denied claims in certain circumstances, and for beneficiary indemnification in certain circumstances. RR does not provide for either program payment or indemnification, but does provide that physicians and suppliers, if held liable under RR provisions, must make refunds to beneficiaries of any amounts collected.

Q.2. Is there some difference in the significance of the beneficiary's signature on an Advance Beneficiary Notice (ABN) depending on whether LOL or RR applies?

A.2. Yes. In order for a beneficiary to be held liable under RR, that is, under §§1834(a)(18), 1834(j)(4), 1842(l), or 1879(h) of the Act, it is necessary that the beneficiary sign the ABN. All the RR provisions require, not only that the beneficiary be notified, but also that the beneficiary agree to pay in order for the beneficiary to be held liable. Thus, an unsigned ABN cannot be used to shift liability to a beneficiary when RR applies. Under LOL, a beneficiary signature is not an absolute requirement. The LOL provision requires only that the beneficiary be properly notified; there is no explicit requirement for an agreement to pay. Therefore, these instructions provide for the situation in which a beneficiary receives an ABN, refuses to sign it, but still demands to receive the services specified on the ABN. In that case, the provider, physician, practitioner, or supplier can annotate the form, with the signature of a witness, that the beneficiary received notice but refused to sign the form, and can submit the claim with an indication that an ABN was given.

Q.3. The ABN forms indicate that, if Medicare denies payment, the beneficiary agrees to be personally and fully responsible for payment and to pay personally, either out of pocket or through any other insurance that the beneficiary has. Why is that, if LOL does not require the beneficiary to agree to make payment?

A.3. The LOL provisions require only that the beneficiary be notified (i.e., agreement to pay is not a requirement); nevertheless, since the beneficiary's signature on an ABN indicating receipt can, and very likely will, result in his or her financial liability under the LOL provisions, the approved ABN form includes agreement to pay language in all cases, as a matter of full disclosure. Consumer testing indicated that beneficiaries appreciated this information and considered it important and necessary for making an informed consumer decision. Furthermore, not including this information on ABNs given in LOL applicable situations could easily mislead beneficiaries to think that they have a third option, i.e., to receive the services and not accept liability; which is not a genuine option under LOL. Under LOL, a beneficiary who is properly notified and who receives a service

which is subsequently denied payment for the reasons cited on the ABN can be held liable, whether or not the beneficiary agreed to make payment. This fact is a significant difference between LOL and RR.

20 - Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed
(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

Section 1879(a)-(g) of the Act provides financial relief to beneficiaries, providers, practitioners, physicians, and other suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare payment would otherwise be denied. This section of the Act is referred to as "the limitation on liability provision."

The basic purpose of this provision is to protect beneficiaries and other claimants from liability in denial cases under certain conditions when services they received are found to be excluded from coverage for one of the reasons specified in §20.1.

Medicare payment under the limitation on liability provision is dependent upon two primary factors. First, the claims for the services or items furnished must have been denied for one of the reasons specified in §20.1. The second factor in determining if Medicare payment is made under the limitation on liability provision is whether the beneficiary and/or the provider, practitioner, physician, or other supplier knew or could reasonably have been expected to know that the items or services (for which Medicare payment was denied on one of the bases specified in §20.1) were not covered. A determination of whether the protection under the limitation on liability provision can be afforded for a denied claim is made as a result of a prepayment medical review or a post-payment audit review. Unfavorable determinations may be appealed.

Where items or services are denied for one of the reasons specified in §20.1, and the other conditions described above are met, the Medicare program makes payment when neither the beneficiary nor the provider, practitioner, or supplier knew, and could not reasonably be expected to have known, that the items or services were not covered. When the beneficiary did not have such knowledge, but the provider, practitioner, or supplier knew, or could have been expected to know, of the exclusion of the items or services, the liability for the charges for the denied items or services rests with the provider, practitioner or supplier. When the beneficiary knew or could have been reasonably expected to know that the items or services were not covered, the liability for the charges rests with the beneficiary, i.e., the beneficiary is responsible for making payment to the provider, practitioner or supplier.

The limitation on liability provision requires the contractor to identify each claim for items or services denied for one of the reasons specified in §20.1. Such denials are processed in

the normal manner except that a special message is entered on the notice to the beneficiary and/or provider, practitioner or supplier. Remittance Advices (RA) to providers, practitioners, or suppliers indicate which items or services were denied for one of the reasons specified in §20.1 in a message included in the RA.

In some cases, the provider, practitioner, or supplier may submit a copy of an advance beneficiary notice (ABN) that satisfies the applicable requirements in §50 - §80. However, if the reason liability is at issue coincides with the end of coverage for a period of care in specific settings-- inpatient hospital, skilled nursing, home health, hospice or comprehensive outpatient rehabilitation facilities-- notification under the expedited determination process will be required as of July 1, 2005. See CR 3903 for preliminary information on the expedited process, including its interaction with liability notice policy.

Note: This chapter often uses the term "ABN" to signify all limitation of liability notices, not just a specific ABN form such as the CMS-R-131.

Providers annotate claims to indicate an ABN was given. In these cases, the contractor should not make an automatic finding that the service is denied for one of the reasons specified in §20.1 merely because an acceptable ABN has been submitted. The fact that there is an acceptable ABN must in no way prejudice the contractor determination as to whether there is or is not sufficient evidence to justify a denial for one of the reasons specified in §20.1.

20.1 - Coverage Denials to Which the Limitation on Liability Applies (Rev. 1, 10-01-03)
B3-7300.2, B3-7300.3, CMS Rulings (No. 95-1, 96-2, 96-3, 97-1)

20.1.1 - Statutory Basis (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A coverage determination for an item or service must be made before there can be a decision with respect to whether Medicare payment may be made under the limitation on liability provision. Medical review entities, acting for the Secretary, are authorized to make the coverage determinations. These entities include A/B MACs and DME MACs, Qualified Independent Contractors (QICs) and Quality Improvement Organizations (QIOs). In CMS Ruling 95-1 and hereafter in these instructions, these entities are referred to collectively as Medicare contractors. These entities must act in accordance with the Medicare statutes, regulations, national coverage instructions, accepted standards of medical practice, and CMS Rulings when making coverage determinations.

The claims payment and beneficiary indemnification provisions (§§1879(a) and (b)) of the limitation on liability provision are applicable only to claims for beneficiary items or services submitted by providers, or by suppliers (which includes physicians or other

practitioners, or an entity other than a provider that furnishes health care services under Medicare) that have taken assignment, and only to claims for services, not otherwise statutorily excluded, that are denied on the basis of §§1862(a)(1), 1862(a)(9) , 1879(e), or 1879(g) of the Act, which, under current law, include the following:

- Services and items found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (§1862(a)(1)(A) of the Act);

- Pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration, furnished to an individual at high or intermediate risk of contracting hepatitis B, that are not reasonable and necessary for the prevention of illness (§1862(a)(1)(B) of the Act);

- Services and items that, in the case of hospice care, are not reasonable and necessary for the palliation or management of terminal illness (§1862(a)(1)(C) of the Act);

- Clinical care services and items furnished with the concurrence of the Secretary and, with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, that are not reasonable and necessary to carry out the purposes of §1886(e)(6) of the Act (which concerns identification of medically appropriate patterns of health resources use) (§1862(a)(1)(D) of the Act);
- Services and items that, in the case of research conducted pursuant to §1142 of the Act, are not reasonable and necessary to carry out the purposes of that section (which concerns research on outcomes of health care services and procedures) (§1862(a)(1)(E) of the Act);

- Screening mammography that is performed more frequently than is covered under §1834(c)(2) of the Act or that is not conducted by a facility described in §1834(c)(1)(B) of the Act and screening pap smears and screening pelvic exams performed more frequently than is provided for under §1861(nn) of the Act (§1862(a)(1)(F) of the Act);

- Screening for glaucoma, which is performed more frequently than is provided under §1861(uu);

- Prostate cancer screening tests (as defined in §1861(oo)), which are performed more frequently than is covered under such section;

- Colorectal cancer screening tests, which are performed more frequently than

is covered under §1834(d);

- The frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;

- Custodial care (§1862(a)(9) of the Act);

- Inpatient hospital services or extended care services if payment is denied solely because of an unintentional, inadvertent, or erroneous action that resulted in the beneficiary's transfer from a certified bed (one that does not meet the requirements of §1861(e) or (j) of the Act) in a skilled nursing facility (SNF) or hospital (§1879(e) of the Act);

- Home health services determined to be noncovered because the beneficiary was not "homebound" or did not require "intermittent" skilled nursing care (as required by §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act) on or after July 1, 1987, and before December 31, 1995 (§1879(g)(1) of the Act); and.

- Hospice care determined to be noncovered because the beneficiary was not "terminally ill" (as required by §1861(dd)(3)(A) of the Act), as referenced by §1879(g)(2) of the Act since BBA 1997

20.1.2 - Dependent Services (Rev. 1, 10-01-03)

When it is determined that Medicare payment will be made under the limitation on liability provision for claims for items or services that were denied for one of the reasons specified in §20.1.1, the payment determination includes claims for any dependent services that are denied as an indirect result of these denials. This longstanding CMS policy is based on the fact that the cause for denial of payment for the qualifying service is the primary cause for denial of the dependent services. For example, where a particular qualifying service is denied as not reasonable and necessary under §1862(a)(1) of the Act, lack of medical necessity is the underlying reason for the denial of the dependent services. Therefore, if the limitation on liability protection applies to the denial of the qualifying service, it will also apply to the dependent service.

For example, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, home health aide services can be covered only if a beneficiary needs intermittent skilled nursing care. When coverage is denied for intermittent skilled nursing services (the qualifying primary services) under §1862(a)(1) or (9) of the Act, home health aide services (the dependent services) likewise are not covered. In such cases, if Medicare payment is made under the limitation on liability provision for the primary services, it would be made for the dependent services as well, provided the services are otherwise covered (that is, all other

conditions for payment of the dependent services are met including a physician's certification of the need for the dependent services and proof that the services are reasonable and necessary).

20.1.3 - Partial Denials Based on Reasonable and Necessary Levels of Care (Rev. 1, 10-01-03)

The limitation on liability protection may also be applicable if a reduction in the level of payment occurs because the furnished services or items are at a level higher than was reasonable and necessary to meet the needs of the patient. This is because Medicare payment for the difference between reasonable and necessary services and items and those actually furnished is denied on the basis of §1862(a)(1)(A) of the Act as not reasonable and necessary. For example, if it is determined that the level of care furnished by a hospice (such as continuous home care) was not reasonable and necessary under §1862(a)(1)(A) because the care could have been given at a lower level (such as routine home care), Medicare payment under the limitation on liability provision may be made for the difference in reimbursement between the denied continuous home care and the approved routine home care if both the beneficiary and provider did not know, or could not reasonably have been expected to know, that payment would not be made for the higher level of care.

The limitation on liability protection may also be applicable if the contractor reduces the level of payment on the basis of §1862(a)(1) of the Act, that is, when partially denying a more extensive service or item on the basis that it is not reasonable and necessary, even though Medicare pays for a less extensive service or item. A case in which the level of payment is reduced because a component of the service or item is in excess of the beneficiary's medical needs is a medical necessity partial denial of that unnecessary component of the covered item or service. "Excess component" means an item, feature, or service, and/or the extent of, number of, duration of, or expense for an item, feature, or service, which is in addition to, or is more extensive and/or more expensive than, the item or service which is reasonable and necessary under Medicare's coverage requirements. For example, a deluxe or aesthetic feature of an upgraded item of medical equipment is an "excess component." Charge increases on the basis of purported premium quality services are not considered to be "excess components" since that would constitute circumvention of payment limits and applicable charging limits (e.g., limiting charges in the case of unassigned claims for physicians' services and fee schedule amounts in the case of assigned claims). The "excess component" definition for partial denials, with respect to an item, feature, or service that is "more expensive" refers to increased charges attributable to furnishing something that is clearly more extensive, that is, more in number, more frequent, for a longer period of time, or with added features; it does not suffice to claim that an item or service is "better" or "higher quality."

20.2 - Denials for Which the Limitation On Liability Provision Does Not Apply

(Rev. 1, 10-01-03)
CMS Ruling 95-1, PM AB-02-168 Part I

Medicare payment under the limitation on liability provision cannot be made when Medicare coverage is denied on any basis other than one of the provisions of the law specified in §20.1.1. (See the Medicare Financial Management Manual, Chapter 3, concerning liability for overpayments arising from other causes.) There are certain claims, however, that may appear to involve a question of medical necessity, as described in §1862(a)(1) of the Act, but the actual Medicare payment denial is based on a statutory provision other than §1862(a)(1). Under these circumstances, Medicare payment under the limitation on liability provision cannot be made because the denial is not based on one of the statutory provisions specified in §20.1.1.

Section 1879(a) of the Act provides that Medicare payment will be made under the limitation on liability provision "when a determination is made that, by reason of §1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g) of the Act, payment may not be made under Part A or Part B" and the conditions described in §1879(a)(2) are met. The statute thus explicitly restricts the application of the limitation on liability provision to cases that are decided on one of the statutory grounds we have specified in §20.1.1. In so providing, the Congress recognized that the issue of medical necessity of a service or item need never be reached if it were determined that the service or item would not otherwise be covered under the statute.

For example, when a Part B claim is submitted for ambulance services, the first step in processing the claim is to determine whether the services meet the requirements of §1861(s)(7) of the Act (that is, to ascertain that other methods of transportation are contraindicated) and, therefore, may be covered services under the Medicare statute. If other methods of transportation are contraindicated (and all other regulatory criteria met), only then must the Medicare contractor determine if the ambulance services are "reasonable and necessary" under §1862(a)(1). If other methods of transportation are not contraindicated, there is no reason for the Medicare contractor to make a medical necessity determination under §1862(a)(1) because the services have already been determined to be not otherwise covered under the Medicare statute.

Therefore, when items or services are denied for any reason other than one of the specific statutory bases for denial specified in §20.1.1, limitation on liability cannot be applied.

20.2.1 - Categorical Denials
(Rev. 1, 10-01-03)

Examples of circumstances in which Medicare payment under the limitation on liability provision cannot be made because the actual Medicare payment denial is based on a statutory provision other than §1862(a)(1) include, but are not limited to, the following

categorical exclusions under §1862(a)(2)-(8) and (10)-(21) of the Act:

Personal comfort items (§1862(a)(6)).

- Routine physicals and most tests for screening (§1862(a)(7)).
- Most shots (vaccinations) (§1862(a)(7)).
- Routine eye care, most eyeglasses and examinations (§1862(a)(7)).
- Hearing aids and hearing examinations (§1862(a)(7)).
- Cosmetic surgery (§1862(a)(10)).
- Orthopedic shoes and foot supports (orthotics) (§1862(a)(8)).
- Dental care and dentures (in most cases) (§1862(a)(12)).
- Routine foot care and flat foot care (§1862(a)(13)).
- Services under a physician's private contract (§1862(a)(19)).
- Services paid for by a governmental entity that is not Medicare (§1862(a)(3)).
- Health care received outside of the U. S. not covered by Medicare (§1862(a)(4)).
- Services by immediate relatives (§1862(a)(11)).
- Services required as a result of war (§1862(a)(5)).
- Services for which there is no legal obligation to pay (§1862(a)(2)).
- Home health services furnished under a plan of care, if the agency does not submit the claim (§1862(a)(21)).
- Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997 (§1862(a)(16)).
- Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need) (§1862(a)(17)).
- Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangement with the hospital (§1862(a)(14)).
- Items and services furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility, unless they are furnished under arrangements by the skilled nursing facility (§1862(a)(18)).
- Services of an assistant at surgery without prior approval from the peer review organization (§1862(a)(15)).
- Outpatient occupational and physical therapy services furnished incident to a physician's services (§1862(a)(20)).

Note: Refer to §1862(a) of the Act for a more complete listing than above.

20.2.2 - Technical Denials

(Rev. 1, 10-01-03)

Examples of circumstances in which Medicare is expected to deny payment for an item or service which may be a Medicare benefit but for which the coverage requirements are not met, include, but are not limited to, the following technical denials:

- Payment for the additional cost of a private room in a hospital or SNF is denied when the privacy accommodations are not required for medical reasons. Medicare payment for the additional cost is denied on the basis of §1861(v)(2) of the Act.

- Payment for a dressing is denied because it does not meet the definition for "surgical dressings" in §1861(s)(5) of the Act. Accordingly, Medicare payment is denied on the basis of §1861(s)(5) of the Act.

- Payment for SNF stays not preceded by the required 3-day hospital stay.

- Payment for SNF stay because the beneficiary did not meet the requirement for transfer to a SNF and for receiving covered services within 30 days after discharge from the hospital and because the special requirements for extension of the 30 days were not met.

- Payment for home health services because they were not ordered on a plan of treatment or subsequent amendment.

- Payment for any form of parenteral and enteral nutrition therapy because the beneficiary did not qualify for the prosthetic device benefit under §1861(s)(8) of the Act.

- Payment for items that do not meet the definition of durable medical equipment (§1861(n)). Such items can never be covered even though in an individual case they may seem medically necessary because of the patient's condition.

- Payment for a medically unreasonable or unnecessary item or service that is also barred because of failure to meet a condition of payment required by regulations, as in the following examples:

a. Drugs and biologicals which are usually self-administered by the patient (§1861(s)(2)(A)&(B));

b. Ambulance services denied because transportation by other means is not contraindicated or because regulatory criteria specified in 42 CFR 410.40, such as those relating to destination or nearest appropriate facility, are not met. In such circumstances, Medicare payment is denied on the basis of §1861(s)(7) of the Act. (See the Medicare Benefit Policy Manual, Chapter 10).

Note: The limitation on liability provision could apply, however, where payment for ambulance services was fully or partially denied as unreasonable, as in the following examples. A transport by air ambulance when the transporting entity has a reasonable

basis to believe that the transport can be done safely and effectively by ground ambulance transportation. A level of care downgrade, e.g., from Advance Life Support (ALS)-2 to ALS-1, or from ALS to Basic Life Support, when the transport at the lower level of care is a covered transport. A transport from a residence to a hospital for a service that can be performed more economically in the beneficiary's home. A transport of a skilled nursing facility patient to a hospital or to another SNF for a service that can be performed more economically in the first SNF.)

c. Other items or services that must be denied under 42 CFR 410.12 through 410.105 of the Medicare regulations.

A reduction in allowed charges results from the contractor's determination that the claim does not meet the reasonable charge criteria, since the authority for reasonable charge reductions is found in §1842. However, when the contractor determines that a claim is to be allowed as a lesser service, the partial denial is based on a decision that the greater service is not reasonable and necessary per §1862(a)(1) and therefore, limitation on liability can apply.

30 - Determining Liability for Disallowed Claims Under §1879
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

See §20 for the criteria that must be met before the contractor considers limitation on liability as discussed in the following subsections.

Ordinarily a finding is made that the beneficiary did not know nor could reasonably have been expected to know that the items or services were not covered by Medicare, unless there is evidence as discussed in §40.2. The procedures for determining whether the provider knew or could reasonably have been expected to know of the noncoverage of services are discussed in §40.1.

30.1 - Determining Beneficiary's Liability
(Rev. 1, 10-01-03)
A3-3432.1, CMS Ruling 95-1, PM AB-02-168

The contractor presumes that the beneficiary did not know that services are not covered **unless** the evidence indicates that written notice was given to the beneficiary. In some cases, the beneficiary may have been given notice in a recent previous claim that a type of care is not covered. More commonly, as indicated above, the provider, practitioner, or supplier gives an ABN to the beneficiary that a particular stay or course of treatment is not covered or that coverage ended at a particular time. (See §40.2 regarding when a beneficiary is on notice of noncoverage.) On any claim to which limitation on liability applies, the beneficiary liability determination is to be made first by the contractor,

followed (as may be necessary) by the provider, practitioner, or supplier liability determination.

30.1.1 - Beneficiary Determined to Be Liable - Right to Appeal (Rev. 1, 10-01-03)

Under §1879(c) of the Act and 42 CFR 411.404, the beneficiary is held to be liable when it is determined that he or she had prior knowledge that Medicare payment for the service or item would be denied or could reasonably have been expected to have had such knowledge. The most likely reason to find that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay is where, before the item or service was furnished, the provider, practitioner, or supplier notified the beneficiary by properly delivering the approved Advance Beneficiary Notice (ABN), of the certainty or likelihood that Medicare would not pay for the specific service. In these instances, the contractor determines that the beneficiary is liable and the beneficiary is held responsible for expenses incurred for services or items for which Medicare payment is denied, regardless of whether the provider, practitioner, or other supplier had knowledge. The Medicare program makes no payment to the beneficiary, provider, practitioner, or other supplier. However, the beneficiary can appeal both the coverage issue, and the contractor's determination of beneficiary liability for the cost of the noncovered care. (See Chapter 29, "Appeals of Claim Decisions.") In a case where a beneficiary received an ABN and, upon initial determination, the claim was paid as covered, that original ABN cannot be used as evidence of knowledge to hold the beneficiary liable in a later case relating to a similar or reasonably comparable service in which the same reason for denial applies, since the original ABN was belied by the favorable payment decision.

30.1.2 - Beneficiary Determined to Be Without Liability (Rev. 1, 10-01-03)

In deciding whether the beneficiary or his/her authorized representative knew, or could reasonably have been expected to know, that payment would not be made for items or services s/he received, the beneficiary's allegation that s/he did not know, in the absence of evidence to the contrary, will be acceptable evidence for LOL purposes. Unless evidence indicates that the beneficiary knew or had reason to know that the items or services received were noncovered, the contractor presumes that the beneficiary did not know that the services are not covered. Under §1879(a)(2) of the Act and the accompanying regulations at 42 CFR 411.400(a)(2), the Medicare program must make payment when the provider, practitioner, or other supplier did not know and could not reasonably have been expected to know that the services or items would be denied. In these instances, the usual deductible and coinsurance amounts apply. The number of days or visits paid for under the limitation on liability provision is charged to the beneficiary's utilization record. Medicare payment may also be made under §1154(a)(2)(B) of the Act and 42 CFR 411.400(b)(2) for a 1-day "grace period" after the date of notice to the provider or to the

beneficiary, whichever is earlier, if additional time is needed to arrange for post-discharge care. If it is determined thereafter by a QIO or the Medicare contractor that even more time is required in order to arrange post-discharge care, 1 additional "grace period" day is paid. Initial approval of 2 or more "grace period" days is not permitted. The "grace period" is applicable only if circumstances would have permitted Medicare program payment under §1879(a)(1) and (2) of the Act and 42 CFR 411.400(b)(2), that is, protection under the limitation on liability provision was afforded both to the beneficiary and the provider; Unless the provider is found to be liable for the items for which the beneficiary was not held liable:

- All days or HHA visits for which the beneficiary received the benefit of limitation on liability (regardless of whether Medicare payment is made) are charged to the beneficiary's utilization record of hospice and SNF days and HHA visits, as though covered under Medicare; and

- Such days and visits are shown as having been used on CMS' notice to the beneficiary.

Under §1879(b) of the Act and 42 CFR 411.402, Medicare does not make payment when it is determined that the provider, practitioner, or other supplier had prior knowledge that Medicare would deny payment for services or items or could reasonably have been expected to have had this knowledge. In these instances, the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied claim and the beneficiary's Medicare utilization record is not charged for the services and items furnished, effective for all services or items furnished on or after January 1, 1988.

30.2 - Determining Provider, Practitioner, or Supplier Liability
(Rev. 1, 10-01-03)
A3-3432.2, CMS Ruling 95-1

30.2.1 - General
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The contractor holds the provider, practitioner, or supplier liable for noncovered services if it is determined that the provider:

- Had actual knowledge of the noncoverage of services in a particular case, or

- Could reasonably have been expected to have such knowledge.

However, it does not hold a provider, practitioner, or supplier liable under §1879 where the provider, practitioner, or supplier indicates on the claim (via Occurrence Code 32 or the HCPCS code modifier "GA" on contractor claims) that they have given the

beneficiary, before furnishing the items or services, an ABN. In such a case, the contractor holds the beneficiary, not the provider, practitioner, or supplier, liable for the denied charges.

30.2.2 - Provider/Practitioner/Supplier is Determined to Be Liable - Right to Appeal
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A provider, practitioner, or supplier that is determined liable for all or a portion of the charges for noncovered items and services furnished a beneficiary may appeal such a decision by the contractor. (See Chapter 29, "Appeals of Claims Decisions.")

Note: Under §1879(b) of the Act and 42 CFR 411.402 et seq., if the provider, practitioner, or other supplier is considered to be liable and requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of the beneficiary's expenses, the Medicare program indemnifies the beneficiary or other person(s) for any amounts paid by the beneficiary. This includes any deductible or coinsurance charges paid by or on behalf of the beneficiary. Further, these indemnification payments are considered an overpayment to the provider, practitioner, or other supplier. The limitation on liability provision applies to third party payers, including liability insurers. Therefore, a provider, practitioner, or supplier that the contractor determines liable may not seek payment from a third party payer without being subject to recovery action that could occur if it sought payment from the beneficiary.

30.2.3 - Provider/Practitioner/Supplier Determined to Be Without Liability
(Rev. 1, 10-01-03)

If the contractor determines that neither the provider, practitioner, or supplier nor the beneficiary knew or had reason to know that the services provided the beneficiary were not covered, the Medicare program will accept liability and make payment. (See §110.1.)

40 - Determining Knowledge for FLP Purposes
(Rev. 1, 10-01-03)
CMS Ruling 95-1

The proper application of all the financial liability protections (FLP) provisions requires determinations about beneficiaries' knowledge (or lack of knowledge), before items and/or services were furnished, that Medicare was certain or likely to deny payment for the items or services. For the protection under the Limitation On Liability (LOL) provision or any Refund Requirements (RR) provision to be afforded, lack of prior knowledge that Medicare payment for the item or service would be denied must first be established. Two

determinations must be made to establish knowledge: first, whether and when the beneficiary knew or should have known that Medicare payment for the item or service would be denied (see §40.2), and, second, whether and when the provider, practitioner, or other supplier knew or should have known that Medicare payment for the item or service would likely be denied (see §40.1). The principles for determining knowledge described in §§40.1 and 40.2 apply, unless otherwise explicitly specified, to determinations of knowledge with respect to denials under these FLP provisions:

- Limitation On Liability (LOL) under §1879(a)-(g);
- Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l); and
- Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h).

40.1 - Determining Whether Provider, Practitioner, or Supplier Had Knowledge of Noncoverage of Services
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The Medicare contractors determine, based on the information they maintain and/or disseminate to a particular provider, practitioner or other supplier, whether the provider, practitioner or other supplier actually had prior knowledge that services or items would likely be denied or whether knowledge reasonably could have been expected. The determination of actual or expected knowledge is based on all the relevant facts pertaining to each particular denial. In accordance with regulations at 42 CFR 411.406 , evidence that the provider, practitioner, or other supplier did, in fact, know or should have known that Medicare would not pay for a service or item includes:

- A Medicare contractor's prior written notice to the provider, practitioner, or other supplier of Medicare denial of payment for similar or reasonably comparable services or items;
- Medicare's general notices to the medical community of Medicare payment denial of services and items under all or certain circumstances (such notices include, but are not limited to, manual instructions, bulletins, contractors' written guides, and directives); and
- Provision of the services and items was inconsistent with acceptable standards of practice in the local medical community (refer to §40.1.3 and §40.1.4).

If any of the circumstances described above exists, a provider, practitioner or other supplier is held to have knowledge.

40.1.1 - Criteria for Determining Practitioner and Other Supplier Knowledge
(Rev. 1, 10-01-03)

The practitioner or other supplier, at the initial determination, is presumed to have had the requisite knowledge of likely Medicare denial of payment for denied services or items and, thereby, to be liable, with one exception. If a practitioner or other supplier gives the beneficiary proper written advance beneficiary notice that Medicare will likely deny payment for the service or item to be furnished, and so documents the claim, the beneficiary is held liable for the denied services or items at the initial determination. Such a notice constitutes proof that both the beneficiary and the practitioner or other supplier had prior knowledge that Medicare payment would be denied for the service or item in question. When both the beneficiary and the practitioner or other supplier are found to have had the requisite knowledge of likely Medicare denial, the beneficiary is held liable. The issue of whether the practitioner or other supplier is liable arises only when the beneficiary has already been found not liable. If the practitioner or other supplier cannot show that the beneficiary received proper written advance beneficiary notice, the practitioner or other supplier will be presumed to have knowledge (and, thereby, liability) unless he/she/it can prove that he/she/it did not know, and could not reasonably have been expected to know, that Medicare would not pay for the service or item. If the practitioner or other supplier can make such a convincing showing, the contractor will find that the practitioner or other supplier did not have the requisite knowledge.

40.1.2 - Criteria for Determining Provider Knowledge
(Rev. 1, 10-01-03)

A provider is always considered to have prior knowledge, and no Medicare payment will be made to any provider for any claim, if previous notification was given or if for any other reason the provider clearly should have known that the claim would be denied. Criteria for determining whether a provider had knowledge or should have had knowledge that services or items would be denied are in regulations at 42 CFR 411.406, which cites various forms and methods of notification that provide sufficient evidence that the provider knew or should have known that the services or items would be denied. Such notices are sufficient notice for all subsequent claims involving that same service or item under similar or reasonably comparable conditions. In general, notification often is provided by one of the following sources:

- The provider's utilization review committee informed the provider in writing that the services were not covered;
- The provider previously submitted a no-payment claim (i.e., a pro forma filing in

which no payment is sought, rather, only a formal payment denial determination is requested), or submitted a claim for Medicare payment only at the request of the beneficiary;

- The provider issued a written advance beneficiary notice of the likelihood of Medicare payment denial for a service or item to the beneficiary;

- Medicare has issued manuals, bulletins, memoranda, etc., advising providers of the noncoverage of a particular service or category of services. All participating providers are issued instructions that discuss and define coverage and noncoverage of specified services under Medicare. For example, instructions in the Medicare Benefit Policy Manual define covered care and provide examples of unskilled services that Medicare does not cover;

- A Medicare contractor previously issued a written notice to the provider that Medicare payment for a particular service or item is denied. This also includes notification of Quality Improvement Organization (QIO) screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical procedures subject to preadmission review by the QIO. Instructions for application of limitation on liability to QIO determinations are in the QIO Manual;

- The provider was previously notified by telephone and/or in writing that care is not covered or that covered care has ended; or

- A general bulletin or newsletter was issued to providers advising that a specific service or item is not considered reasonable and necessary.

The provider is accountable for information contained in the patient's medical records, such as the patient's medical chart, attending physicians' notes, or similar records, since these are provider records. Where it is clear and obvious from review of a particular medical record that the patient received only noncovered services described in the Medicare Benefit Policy Manual, the provider is held to have knowledge of noncoverage. Clear-cut decisions as to noncovered care may not be possible in some cases since patients may, for example, require a combination of skilled and unskilled services during a SNF stay or when receiving services at home. Evidence based upon medical records, such as that described in the following list, clearly indicates knowledge that Medicare payment for services or items would be denied and the date of such knowledge:

- A physician clearly indicated in the patient's medical record that the patient no longer needed the services or the level of care provided;

- The physician indicated the patient could be discharged;

- The attending physician refused to certify or recertify the patient's need for a particular level of care covered by Medicare because he/she determined that the patient does not require a covered level of care; or

- The contractor requested additional medical evidence after a certain number of days to determine whether continued coverage is warranted. However, the provider did not submit the evidence within the stipulated time.

Example: Based on an admission notice and medical information, it was conditionally projected that SNF coverage was likely to extend for 12 days. The SNF must submit additional evidence of coverage within the 12 days. If the SNF failed to do so, its liability can be waived only through the 12th day of the stay, if the contractor later determined the services were not covered under §1862(a)(l) or (9). The contractor follows the established procedure for requesting additional evidence needed in a particular case to permit a decision on coverage. Where the beneficiary is still an inpatient at the SNF, the contractor advises the SNF that the additional information must be submitted (i.e., postmarked), within five workdays of a telephone request, or if a telephone request is not feasible, postmarked within seven workdays of the date of a written request. If this requirement is met, the SNF is protected from liability under the limitation on liability provision through the date the contractor made the coverage determination based on the requested additional evidence and notified the SNF. If the evidence is not submitted within the required five to seven days, the SNF is protected from liability only through the date the additional evidence was requested.

40.1.3 - Acceptable Standards of Practice (Rev. 1, 10-01-03)

In situations in which services or items furnished do not meet locally acceptable standards of practice, the provider, practitioner, or other supplier is considered to have known that Medicare payment for the services or items would be denied. Providers, practitioners, and other suppliers are always responsible for knowing locally acceptable standards of practice; their local licensure is premised on the assumption that they have such knowledge. Medicare payment to providers, practitioners, or other suppliers is premised on the presumption that they have such knowledge, as evidenced by their licensure. No other evidence of knowledge of local medical standards of practice is necessary. Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the

American Medical Association." By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine.

40.1.4 - Fraud, Abuse, Patently Unnecessary Items and Services (Rev. 1, 10-01-03)

Generally, the protection under the financial liability protections provisions (LOL and RR) cannot be afforded to providers, practitioners, or other suppliers if a formal finding of fraud or abuse has been made with regard to a provider's, practitioner's, or other supplier's billing practices. In cases in which a formal finding of fraud or abuse is made, an immediate finding of liability for the provider, practitioner, or other supplier results. The contractor makes an immediate finding of liability, not only in fraud and abuse, but also in other situations where a provider, practitioner, or other supplier furnishes and claims payment for services that are so patently unnecessary that all providers, practitioners, and other suppliers could reasonably be expected to know that they are not covered. Generally, this would be the case where abuse has been identified in a particular claim. Abuse exists when a provider, practitioner, or other supplier furnishes services that are inconsistent with accepted sound medical practices, are clearly not within the concept of reasonable and necessary as defined by law or regulations, and, if paid for, would result in an unnecessary financial loss to the program.

40.2 - Determining Whether Beneficiary Had Knowledge of Noncoverage of Services (Rev. 1, 10-01-03) CMS Ruling 95-1, A3-3439.1, B3-7300.5

40.2.1 - Beneficiary Knowledge Standards (Rev. 1, 10-01-03)

Beneficiary knowledge standards vary between the §1879 LOL provision and the two Refund Requirements, for physician services and for medical equipment and supplies.

Limitation On Liability - §1879(a)(2) of the Act requires that the beneficiary "did not know, and could not reasonably have been expected to know, that payment would not be made* * *," for items or services that are excluded from coverage for one of the reasons specified in §20.1, in order for the LOL protection to be afforded. This includes knowledge based on written notice having been provided to the beneficiary, as well as any other means from which it is determined that the beneficiary knew, or should have known, that payment would not be made.

Physician Refund Requirement - §1842(l)(1)(C)(ii) requires that "before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service," that is, for physician services that are denied because they were not reasonable and necessary under §1862(a)(1) of the Act, in order for the refund requirement protection to be afforded.

Medical Equipment and Supplies Refund Requirement - §1834(a)(18)(A)(ii) [which is incorporated by reference into §1834(j)(4) and §1879(h)] requires that "before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item," that is, for medical equipment and supplies denied on the basis of §1834(a)(17)(B), §1834(j)(1), §1834(a)(15), or
§1862(a)(1) of the Act, in order for the refund requirement protection to be afforded.

In both Refund Requirement cases, the beneficiary's knowledge must be evidenced by a signed advance beneficiary notice and agreement to pay personally in case of a denial.

40.2.2 - Written Notice as Evidence of Knowledge (Rev. 1, 10-01-03)

The CMS regulations at 42 CFR 411.404 provide one basis for determining beneficiary knowledge that payment would not be made for items or services that are excluded from coverage. These regulations provide that a beneficiary will be considered to know, **based on written notice**, that services or items were excluded from coverage. Under these regulations, there is a presumption that he or she knew, or could reasonably have been expected to know, that Medicare payment for a service or item would be denied if advance written notice has been given either to the beneficiary or to someone acting on his or her behalf that the items or services were not covered.

In accordance with 42 CFR 411.404, a written notice of Medicare denial of payment must contain sufficient information to enable the beneficiary to understand the basis for the denial. Such notice constitutes sufficient documentation to show that the beneficiary had prior knowledge of the likelihood of denial of that claim, and of future claims filed by, or on behalf of, the beneficiary that involve that same or a similar item or service. In addition, a written notice of Medicare denial of payment from a Medicare contractor for a recent previous claim for a particular service or item received by the beneficiary serves as prior written notice for future claims filed by or on behalf of the beneficiary that involve that same or a similar service or item. A notice that a beneficiary received within the twelve months before the claims denial at issue may be considered as evidence of prior knowledge with respect to such same or similar service or item that is denied payment by Medicare for the same reason in both the earlier and the later cases.

40.2.3 - Sources of Written Notice (Rev. 1, 10-01-03)

Generally, the required written notice of the certainty or likelihood of Medicare payment denial must be furnished to the beneficiary (or to the beneficiary's authorized representative) by:

- A provider, practitioner, or other supplier before the service or item was furnished;
- The provider, after the Medicare contractor, during the course of the patient's stay, advised the provider that covered care had ceased;
- A provider utilization review committee that, on admission or during the patient's stay, advised that the patient no longer required covered care; or
- The Medicare contractor.

40.2.4 - Other Evidence of Knowledge (Rev. 1, 10-01-03)

While 42 CFR 411.404 provides criteria for beneficiary knowledge based on written notice, §1879(a)(2) of the Act specifies only that knowledge must not exist in order to apply the limitation on liability protection. If it is clear and obvious that a beneficiary in fact did know, prior to receiving a service or item, that Medicare payment for that service or item would be denied, the administrative presumption favorable to the beneficiary referred to in 42 CFR 411.404, is rebutted. For example, if the beneficiary admits that he or she had prior knowledge that payment for a service or item would be denied, no further evidence is required; the absence of a written notice is moot.

The failure of any provider, practitioner, or other supplier to furnish to a beneficiary proper advance notice of the likelihood of denial is not sufficient to afford the beneficiary the protection of the limitation on liability provision if the contractor has proof that the beneficiary, nonetheless, had the requisite knowledge that the service would be denied. In any case in which the contractor has such evidence of prior knowledge on the beneficiary's part, the beneficiary must be held liable under the limitation on liability provision.

40.3 - Advance Beneficiary Notice Standards (Rev. 1, 10-01-03) PM AB-02 168

The purpose of the ABN is to inform a Medicare beneficiary, before he or she receives specified items or services that otherwise might be paid for, that Medicare certainly or probably will not pay for them on that particular occasion. The ABN, also, allows the

beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance. In addition, the ABN allows the beneficiary to better participate in his/her own health care treatment decisions by making informed consumer decisions. If the provider, practitioner, or supplier expects payment for the items or services to be denied by Medicare, the provider, practitioner, or supplier must advise the beneficiary before items or services are furnished that, in its opinion, the beneficiary will be personally and fully responsible for payment. To be "personally and fully responsible for payment" means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or other Federal or non-Federal payment source. The provider, practitioner, or supplier must issue an ABN each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made. A provider, practitioner, or supplier (that is, a qualified notifier as defined in §40.3.2), shall notify a beneficiary by means of timely (as defined in §40.3.3) and effective (as defined in §40.3.4) delivery of a proper notice document (as defined in §40.3.1) to a qualified recipient, viz., to the individual beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Any Advance Beneficiary Notice (ABN) must meet the following notice standards in order to be acceptable as evidence of the beneficiary's knowledge for the purposes of the FLP provisions, LOL and RR, except as otherwise explicitly specified. A notification which does not meet the following ABN standards may be ruled defective and may not serve to protect the interests of the notifier (provider, practitioner, or supplier). Any requirement to furnish a notice to a beneficiary is not met by delivery of a defective notice.

40.3.1 - Proper Notice Documents (Rev. 1, 10-01-03)

When, for a particular purpose, an approved standard form (e.g., Form CMS-R-131, Form CMS-R-296) exists, it constitutes the proper notice document. Notices not using a mandatory standard notice form may be ruled defective. In the absence of such a standard form, approved model notice language constitutes the proper notice document. A notifier's unapproved modification of either a standard form or model notice language may render that notice defective.

40.3.1.1 - Readability Requirements (Rev. 1, 10-01-03)

Both the originals and copies of ABNs must meet the following conditions to facilitate beneficiary understanding:

- Do not use italics, nor any font that is difficult to read, nor reversed print (e.g., white on black). Examples of easily readable fonts include, but are not limited to, Arial, Arial Narrow, Times Roman, Courier. On standard forms, the published

fonts may not be changed to any other font;

- Use at least a 12 point font size;
- Use a visually high-contrast combination of dark ink on a pale background.
- Do not block-shade ("highlight") notice text; and
- Insertions in forms' blanks, if any, must be typed, printed, or legibly handwritten.

40.3.1.2 - Specificity, Delivery, and Receipt (Rev. 1, 10-01-03)

An ABN must:

Be written in lay language;

Cite the particular items or services for which payment will be or is likely to be denied;

Cite the notifier's reasons for believing Medicare payment will be or is likely to be denied. (See §40.3.8);

Be delivered by a qualified notifier to the beneficiary (or to the beneficiary's authorized representative), before those items or services were furnished; and

Be received by, and its contents must be comprehended by, the beneficiary (or authorized representative).

40.3.1.3 - Defective Notice (Rev. 1, 10-01-03)

An ABN is not acceptable evidence if:
The notice is unreadable, illegible, or otherwise incomprehensible, or the individual beneficiary (or authorized representative) is incapable of understanding the notice due to the particular circumstances (even if others may understand);

The notice is given during any emergency, or the beneficiary is under great duress, or the beneficiary (or authorized representative) is, in any way, coerced or misled by the notifier, by the contents of the notice, and/or by the manner of delivery of the notice. (See §40.3.7); The notifier routinely gives this notice to all beneficiaries for whom the notifier furnishes items or services. (See §40.3.6); The notice is no more than a statement to the effect that there is a possibility that Medicare may not pay for the items or services. (See §40.3.6); or

The notice was delivered to the beneficiary (or authorized representative) more than one year before the items or services are furnished.

Note: A previously furnished ABN is acceptable evidence of notice for current items or services if the previous ABN cites similar or reasonably comparable items or services for which denial is expected on the same basis in both the earlier and the later cases. A written denial (on the same basis in both the earlier and the later cases) of payment from a Medicare contractor for a claim for the same or similar items or services received by the beneficiary not more than one year previously is acceptable evidence of notice for current items or services.

40.3.2 – Qualified Notifiers
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

An ABN must be delivered to the beneficiary (or authorized representative) by a qualified notifier such that the beneficiary (or authorized representative) may have confidence in and rely upon the accuracy and credibility of the notice. A QIO, contractor, group or committee responsible for utilization review for the provider that furnished the services, or provider, practitioner, or supplier that furnished or ordered the items and/or services (including their staff and employees) is a qualified notifier for delivery of ABNs for the purposes of the limitation on liability provision and the refund requirements provisions. In this section, when explaining the "notifier's" liability risks, etc., it is generally the provider, practitioner, or supplier that furnished or ordered the items and/or services to which reference is made.

40.3.3 - Timeliness
(Rev. 1, 10-01-03)

A beneficiary must be notified far enough in advance of an event about which a decision must be made by the beneficiary (e.g., receiving a medical service) so that the beneficiary can make a rational, informed consumer decision without undue pressure. Last minute notification can be coercive, and a coercive notice is a defective notice. ABN delivery should take place before a procedure is initiated and before physical preparation of the patient (e.g., disrobing, placement in or attachment of diagnostic or treatment equipment) begins. This standard does not constitute a blanket prohibition on delivery of notice after a beneficiary has entered an examination room, a draw station, a sales room, and is ready to receive services or items. If a situation arises during an encounter when a notifier sees a need for a previously unforeseen service and expects that Medicare will not pay for it, delivery of a notice is permissible, provided that the beneficiary is capable of receiving notice and has a meaningful opportunity to act on it (e.g., the beneficiary is not under general anesthesia). Where it is foreseeable that the need for service for which

Medicare likely would not pay may arise during the course of an encounter, and the beneficiary is either certain or likely not to be capable of receiving notice during the initial service (e.g., the beneficiary will be under anesthesia), it is permissible to give notice before any service is initiated).

40.3.4 - Effective Delivery (Rev. 1, 10-01-03)

Delivery of a notice occurs when the beneficiary (or authorized representative) both has received the notice and can comprehend its contents.

40.3.4.1 - Basic Delivery Requirements (Rev. 1, 10-01-03)

The notifier should hand-deliver the ABN to the beneficiary or authorized representative. (Where hand-delivery is impossible, e.g., in furnishing items and services by telephone order, mail order, over the internet, etc., ABNs still need to be executed in advance of furnishing the item or service, e.g., by mail, fax, using an online form) Delivery is the notifier's responsibility. The contractor will consider delivery of an ABN by a notifier's staff or employees to be delivery by the notifier. If the beneficiary alleges non-receipt of notice and the notifier cannot show that notice was received by the beneficiary, the contractor will not find that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay; i.e., it will hold the notifier liable and the beneficiary not liable. The ABN must be prepared with an original and at least one copy. The notifier must retain the original and give the copy to the beneficiary or authorized representative. (In a case where the notifier that gives an ABN is not the entity which ultimately bills Medicare for the item or service, e.g., when a physician draws a test specimen and sends it to a laboratory for testing, the notifier should give a copy of the signed ABN to the entity which ultimately bills Medicare.) The copy is given to the beneficiary immediately after the beneficiary signs it. Legible duplicates (carbons, etc.), fax copies, electronically scanned copies, or photocopies will suffice. This is a fraud and abuse prevention measure. If a beneficiary is not given a copy of the ABN and if the beneficiary later alleges that the ABN presented to the contractor by the notifier is different in any material respect from the ABN he/she signed, the contractor will give credence to the beneficiary's allegations.

40.3.4.2 - Telephone Notice (Rev. 1, 10-01-03)

The contractor will not consider a telephone notice to a beneficiary, or authorized representative, to be sufficient evidence of proper notice for limiting any potential liability, unless the content of the telephone contact can be verified and is not disputed by the beneficiary. If a telephone notice was followed up immediately with a mailed notice or

a personal visit at which written notice was delivered in person and the beneficiary signed the written notice accepting responsibility for payment, the contractor will accept the time of the telephone notice as the time of ABN delivery.

40.3.4.3 - Capable Recipient
(Rev. 1, 10-01-03)

The contractor will not consider delivery of a notice to be properly done unless the beneficiary, or authorized representative, was able to comprehend the notice (i.e., they were capable of receiving notice). A comatose person, a confused person (e.g., someone who is experiencing confusion due to senility, dementia, Alzheimer's disease), a legally incompetent person, a person under great duress (for example, in a medical emergency) is not able to understand and act on his/her rights, therefore necessitating the presence of an authorized representative for purposes of notice. A person who does not read the language in which the notice is written, a person who is not able to read at all or who is functionally illiterate to read any notice, a blind person or otherwise visually impaired person who cannot see the words on the printed page, or a deaf person who cannot hear an oral notice being given by phone, or could not ask questions about the printed word without aid of a translator, is a person for whom receipt of the usual written notice in English may not constitute having received notice at all (this is not an exclusive list). This may be remedied when an authorized representative has no such barrier to receiving notice. However, in the absence of an authorized representative, the notifier must take other steps to overcome the difficulty of notification. These may include providing notice in the language of the beneficiary (or authorized representative), in Braille, in extra large print, or by getting an interpreter to translate the notice, in accordance with the needs of the beneficiary or authorized representative to act in an informed manner. If the beneficiary was not capable of receiving the notice, the contractor will hold that the beneficiary did not receive proper notice, hold that the beneficiary is not liable, and will hold the notifier liable.

40.3.4.4 - Responsiveness to Inquiries
(Rev. 1, 10-01-03)

The contractor will hold that a beneficiary did not receive proper notice in any case where it finds that the notifier refused to answer inquiries from a beneficiary, or authorized representative, who requested further information and/or assistance in understanding and responding to the notice, including the basis for its assessment that items or services may not be covered.

40.3.4.5 - Identification of Notifier
(Rev. 1, 10-01-03)

In the case of an ABN on which the notifier's identifying information in the header of the ABN form identifies the entity or person that obtained the ABN, rather than the entity or person that is billing for the services (e.g., when one laboratory refers a specimen to another laboratory which then bills Medicare for the test; when a physician executes an ABN with his or her own identifying information in the header in conjunction with ordering a laboratory test for which the testing laboratory will submit the claim to Medicare), the contractor will consider the ABN form to be valid so long as it was otherwise properly executed.

40.3.4.6 - Dealing With Beneficiary Refusals

(Rev. 1, 10-01-03)

A beneficiary (or authorized representative) who has been given an ABN may decide to receive the item or service. In this case, the beneficiary should indicate that he/she is willing to be personally and fully responsible for payment. When a beneficiary decides to decline an item or service, he/she should so indicate. The beneficiary cannot properly refuse to sign the ABN at all and still demand the item or service. If a beneficiary refuses to sign a properly executed ABN, the notifier should consider not furnishing the item or service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option. Additionally, the notifier may annotate the ABN, and have the annotation witnessed, indicating the circumstances and persons involved.

A. In the case of claims to which Limitation on Liability protections under §1879 of the Act apply, if the notifier does furnish the item or service, the beneficiary's signature is meant to attest to receipt of the ABN; it has "agreement to pay" language so that it is absolutely clear to the beneficiary what the implications for him or her are. Once the beneficiary has read a properly executed ABN, he or she is "on notice"; that is, the beneficiary "knew, or could reasonably have been expected to know, that payment could not be made." The beneficiary has two legitimate choices: (a) To obtain the service and be prepared to pay out of pocket, that is, personally or by any other insurance coverage, or (b) Not to obtain the service. If the beneficiary demands the service and refuses to pay, the notifier should have a second person witness the provision of the ABN and the beneficiary's refusal to sign. They should both sign an annotation on the ABN attesting to having witnessed said provision and refusal. Where there is only one person on site (e.g., in a "draw station"), the second witness may be contacted by telephone to witness the beneficiary's refusal to sign the ABN by telephone and may sign the ABN annotation at a later time. An unused patient signature line on the ABN form may be used for such an annotation; writing in the margins of the form is also permissible. The notifier should file its claim as having given the ABN. The beneficiary will be held liable per §1879(c) of the Act in case of a denial.

B. In the case of claims to which Refund Requirement protections under §§1834(a)(18), 1834(j)(4), 1842(l), or §1879(h) of the Act apply, if the physician or supplier does furnish the item or service, the beneficiary's signature is meant to attest both to receipt of the ABN and to the beneficiary's agreement to pay. The beneficiary both must receive a properly executed ABN so that he or she is "on notice" (that is, the beneficiary "knew, or could reasonably have been expected to know, that payment could not be made") and must agree to pay. The beneficiary has the same two legitimate choices: (a) To obtain the service and be prepared to pay out of pocket, that is, personally or by any other insurance coverage, or (b) Not to obtain the service. If the beneficiary demands the service and refuses to pay (will not sign or else marks out the agreement to pay language), the physician or supplier must take into account the fact that it will not be able to collect from the beneficiary in deciding whether or not to furnish the items or services. Although there would be little point in having a second person witness the provision of the ABN and the beneficiary's refusal to agree to pay (because the requirement that the beneficiary agree to pay still would not be fulfilled), the physician or supplier may annotate the ABN, as described above. The physician or supplier, if the items or services are furnished despite the beneficiary's refusal to pay, should file the claim as not having obtained a signed ABN, since it was not completed properly by the beneficiary. The contractor will not hold the beneficiary liable per §§1834(a)(18), 1834(j)(4), 1842(l), or §1879(h) of the Act in case of a denial and will hold the physician or supplier liable.

C. In either case, the beneficiary who does receive an item or service, of course, always has the right to a Medicare determination and the claim must be filed with Medicare.

40.3.5 - Authorized Representatives (Rev. 1, 10-01-03)

An authorized representative is a person who is acting on the beneficiary's behalf and in the beneficiary's best interests, and who does not have a conflict of interests with the beneficiary, when the beneficiary is temporarily or permanently unable to act for himself or herself. A notifier's inability to give notice to a beneficiary directly or through an authorized representative does not allow the notifier to shift liability to the beneficiary.

An individual authorized under state law to make health care decisions, e.g., a legally appointed representative or guardian of the beneficiary (if, for example, the beneficiary has been legally declared incompetent by a court), or an individual exercising explicit legal authority on the beneficiary's behalf (e.g., in accordance with a properly executed "durable medical power of attorney" statement or similar document), may be the authorized representative of the beneficiary with respect to receiving notice.

An authorized representative should have the beneficiary's best interests at heart and should be reasonably expected to act in a manner which is protective of the person and the rights of the beneficiary. In the absence of some more compelling consideration, the order of priority of authorized representatives is:

A. The spouse, unless legally separated.
B. An adult child.
C. A parent.
D. An adult sibling.
E. A close friend (defined as "an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available").

An authorized representative should have no relevant conflict of interests with the beneficiary. A notifier (including the notifier's employees) that has a conflicting interest (such as shifting financial liability to the beneficiary) is not qualified to be an authorized representative.

A person (typically, a family member or close friend) whom the beneficiary has indicated may act for him or her, but who has not been named in any legally binding document conveying such a role to that person may be an authorized representative. In states which have health care consent statutes providing for health care decision-making by surrogates on behalf of patients who lack advance directives and guardians, reliance upon individuals appointed or designated under such statutes to act as authorized representatives is permissible, as may be necessary.

In case of necessity, a disinterested third party, such as a public guardianship agency, may be an authorized representative, e.g., where the beneficiary's inability to act has arisen suddenly (e.g., a medical emergency, a traumatic accident, an emotionally traumatic incident, disabling drug interaction, stroke, etc.), and there is no one who can be genuinely considered to be the beneficiary's choice as his or her authorized representative.

40.3.6 - Routine Notice Prohibition (Rev. 1, 10-01-03)

In general, the "routine" use of ABNs is not effective. By "routine" use, CMS means giving ABNs to beneficiaries where there is no specific, identifiable reason to believe Medicare will not pay. Notifiers should not give ABNs to beneficiaries unless the notifier has some genuine doubt that Medicare will make payment as evidenced by their stated reasons. Giving routine notices for all claims or services is not an acceptable practice. If the

contractor identifies a pattern of routine notices in situations where such notices clearly are not effective, it will write to the notifier and remind it of these standards. In general, routinely given ABNs are defective notices and will not protect the notifier from liability. However, ABNs may be routinely given to beneficiaries when all or virtually all beneficiaries may be at risk of having their claims denied. §40.3.6.4 specifies circumstances in which ABNs may be routinely given.

40.3.6.1 - Generic ABNs (Rev. 1, 10-01-03)

"Generic ABNs" are routine ABNs to beneficiaries which do no more than state that Medicare denial of payment is possible, or that the notifier never knows whether Medicare will deny payment. Such "generic ABNs" are not considered to be acceptable evidence of advance beneficiary notice. The ABN must specify the service and a genuine reason that denial by Medicare is expected. ABN standards likewise are not satisfied by a generic document that is little more than a signed statement by the beneficiary to the effect that, should Medicare deny payment for anything, the beneficiary agrees to pay for the service. "Generic ABNs" are defective notices and will not protect the notifier from liability.

40.3.6.2 - Blanket ABNs (Rev. 1, 10-01-03)

A notifier should not give an ABN to a beneficiary unless the notifier has some genuine doubt regarding the likelihood of Medicare payment as evidenced by its stated reasons. Giving ABNs for all claims or items or services (i.e., "blanket ABNs") is not an acceptable practice. Notice must be given to a beneficiary on the basis of a genuine judgment about the likelihood of Medicare payment for that individual's claim.

40.3.6.3 - Signed Blank ABNs (Rev. 1, 10-01-03)

A notifier is prohibited from obtaining beneficiary signatures on blank ABNs and then completing the ABNs later. An ABN, to be effective, must be completed before delivery to the beneficiary. The contractor will hold any ABN that was blank when it was signed to be defective notice that will not protect the notifier from liability.

40.3.6.4 - Routine ABN Prohibition Exceptions (Rev. 1, 10-01-03)

ABNs may be routinely given to beneficiaries and considered to be effective notices which will protect notifiers in the following exceptional circumstances:

A. **Services Which Are Always Denied for Medical Necessity -** In any case where a national coverage decision provides that a particular service is never covered, under any circumstances, as not reasonable and necessary under §1862(a)(1) of the Act (e.g., at present, all acupuncture services by physicians are denied as not reasonable and necessary), an ABN that gives as the reason for expecting denial that: "Medicare never pays for this item/service" may be routinely given to beneficiaries, and no claim need be submitted to Medicare. If the beneficiary demands that a claim be submitted to Medicare, the notifier should submit the claim as a demand bill.

B. **Experimental Items and Services -** When any item or service which Medicare considers to be experimental (e.g., "Research Use Only" and "Investigational Use Only" laboratory tests) is to be furnished, since all such services are denied as not reasonable and necessary under §1862(a)(1) of the Act because they are not proven safe and effective, the beneficiary may be given an ABN that gives as the reason for expecting denial that: "Medicare does not pay for services which it considers to be experimental or for research use." Alternative, more specific, language with respect to Medicare coverage for clinical trials may be substituted as necessary as the ABN's reason for expecting denial.

C. **Frequency Limited Items and Services -** When any item or service is to be furnished for which Medicare has established a statutory or regulatory frequency limitation on coverage, or a frequency limitation on coverage on the basis of a national coverage decision or on the basis of the contractor's local medical review policy (LMRP), because all or virtually all beneficiaries may be at risk of having their claims denied in those circumstances, the notifier may routinely give ABNs to beneficiaries. In any such routine ABN, the notifier must state the frequency limitation as the ABN's reason for expecting denial (e.g., "Medicare does not pay for this item or service more often than **frequency limit**").

D. **Medical Equipment and Supplies Denied Because the Supplier Had No Supplier Number or the Supplier Made an Unsolicited Telephone Contact** - Given that Medicare denials of payment under §1834(j)(1) of the Act on the basis of a supplier's lack of a supplier number, and under §1834(a)(17)(B) of the Act, the prohibition on unsolicited telephone contacts, apply to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally, the usual prohibition on provision of routine notices to all beneficiaries does not apply in these cases.

Note: A routine ABN, like any other ABN, is effective only for the reason for expecting denial that is specified on the ABN. Such a routine ABN will not be effective notice, that is,

will not shift liability to the beneficiary, in the case of any Medicare denial of the claim for any reason other than that specified on the ABN.

40.3.7 - Standards for Situations Where the Beneficiary is in a Medical Emergency or Is Otherwise Under Great Duress
(Rev. 1, 10-01-03)

An ABN should not be obtained from a beneficiary in a medical emergency or otherwise under great duress (i.e., when circumstances are compelling and coercive) since that individual cannot be expected to make a reasoned informed consumer decision. In genuine emergencies, the beneficiary/victim and his or her family/friends (authorized representative) are under great duress, by the emergency circumstances, to sign anything in order to obtain help. On the other hand, there is a risk that beneficiaries might actually forego needed emergency services if faced with a financial burden which they believe they cannot bear. A requirement for delivery of a notice is that the beneficiary, or authorized representative, must be able to comprehend the notice, i.e., they must be capable of receiving notice (see §40.3.4.3). A person under great duress is not able to understand and act on his or her rights. If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held liable where the LOL or RR provisions apply, and the notifier may be held liable.

40.3.7.1 - Emergency Medical Treatment and Active Labor Act (EMTALA) Situations
(Rev. 1, 10-01-03)

An ABN should not be given to a beneficiary in any case in which EMTALA (§1876 of the Act) applies, until the hospital has met its obligations under EMTALA, which includes completion of a medical screening examination (MSE) to determine the presence or absence of an emergency medical condition, or until an emergency medical condition has been stabilized. The CMS published this policy in the November 10, 1999 OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute: “A hospital would violate the patient anti-dumping statute if it delayed a medical screening examination or necessary stabilizing treatment in order to prepare an ABN and obtain a beneficiary signature. The best practice would be for a hospital not to give financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual’s agreement to pay for services before the individual is stabilized. This is because the circumstances surrounding the need for such services, and the individual’s limited information about his or her medical condition, may not permit an individual to make a rational, informed consumer decision.” This policy applies in any case in which EMTALA applies, not only to EMTALA cases seen in emergency rooms (ERs). Giving ABNs to beneficiaries under great duress is not permitted, regardless of the particular treatment setting or location. Even when a beneficiary does not appear to have a life threatening

condition, rather, he or she is seeking primary care services at an ER, an ABN should not be given to the beneficiary in any case in which EMTALA applies until the hospital has met its obligations under EMTALA. An ABN that is otherwise appropriate may be given to a Medicare beneficiary who is seen in the ER after completion of an MSE, but an ABN should not be given unless there is a genuine reason to expect that Medicare will deny payment for the services because giving routine "blanket" ABNs to beneficiaries is not permitted (see §40.3.6.2). There always must be a reason for expecting that Medicare will deny payment for the services furnished to the individual beneficiary on a specific occasion, and that reason must appear on the ABN. EMTALA does not prohibit asking payment questions entirely, rather, only doing so before screening/stabilization. After screening/stabilization, EMTALA no longer applies and ABNs may be given, when otherwise appropriate, to beneficiaries who come to emergency care settings after they have received a medical screening examination and are stabilized.

40.3.7.2 - Other Situations (Rev. 1, 10-01-03)

A provider, practitioner, or supplier may not shift liability to a beneficiary under great duress by giving an ABN to the beneficiary. ABNs given to any individual who is under great duress cannot be considered to be proper notice. It is inconsistent with the purpose of advance beneficiary notice, which is to facilitate an informed consumer decision by a beneficiary whether or not to receive an item or service and pay for it out-of-pocket, to attempt to obtain beneficiaries' signatures on ABNs during medical emergencies and other compelling, coercive circumstances where a rational, informed consumer decision cannot reasonably be made. For that reason, providers, practitioners, and suppliers may not use ABNs to shift financial liability to beneficiaries in emergency care situations. Ambulance companies may not give ABNs to beneficiaries or their authorized representatives in any emergency transport because such beneficiaries are under great duress. Skilled nursing facilities may not give ABNs in the case of "middle-of-the-night" emergencies or in any other emergency circumstances, since the beneficiary clearly cannot make an informed consumer decision. The contractor will consider any ABN given in any kind of coercive circumstances, including medical emergencies, to be defective. In all such coercive situations, the contractor will find that the beneficiary did not know and could not reasonably have been expected to know that Medicare would not make payment. The contractor will determine the provider's, practitioner's, or supplier's liability by the appropriate knowledge standards which are used in cases where ABNs are not given and beneficiary agreements to pay are not obtained. This policy regarding duress applies in any case in which a beneficiary is under great duress and cannot make an informed consumer decision. This is the basis for the "last moment delivery" policy that a beneficiary must be notified well enough in advance of receiving a medical service so that the beneficiary can make a rational, informed consumer decision. In any case of such "last moment delivery" of an ABN, the delivery may not be considered timely and the beneficiary may not be held liable.

40.3.8 - Reason for Predicting Denial
(Rev. 1, 10-01-03)

Statements of reasons for predicting Medicare denial of payment at a level of detail similar to the approved "Medical Necessity" messages for MSNs are acceptable for ABN purposes. Simply stating "medically unnecessary" or the equivalent is not an acceptable reason, insofar as it does not at all explain why the physician or supplier believes the items or services will be denied as not reasonable and necessary. To be acceptable, the ABN must give the beneficiary a reasonable idea of why the notifier is predicting the likelihood of Medicare denial so that the beneficiary can make an informed consumer decision whether or not to receive the service and pay for it personally. Listing several reasons which apply in different situations without indicating which reason is applicable in the beneficiary's particular situation generally is not an acceptable practice, and such an ABN may be defective and may not protect the notifier from liability. However, if more than one reason for denial could apply (e.g., exceeding a frequency limit and "same day" duplication; cases where the reason for denial could depend upon the result of a test; etc.), the contractor will not invalidate an ABN on the basis of citing more than one reason for denial.

50 - Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.1 - Introduction - General Information
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Section 50 of the Medicare Claims Processing Manual establishes the standards for use by providers and suppliers (including laboratories) in implementing the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131. This section provides instructions regarding the notice issued by providers to beneficiaries in advance of providing what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30.

ABN - Quick Glance Guide[1]

Notice Name: Advance Beneficiary Notice of Noncoverage (ABN)
Notice Number: Form CMS-R-131
Issued by: Providers and suppliers of Medicare Part B items and services; Hospice and Religious Non-medical HealthCare Institute (RNHCI) providing Medicare Part A items and services; and home health agencies(HHAs) for Part A and Part B items and services

Recipient: Original Medicare (fee for service) beneficiary
Additional Information:
The ABN, Form CMS-R-131 replaces the following notices:

- ABN-G
- ABN-L
- Notice of Exclusion of Medicare Benefits (NEMB)
- Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R- 296, Option Box 1 (effective 2013)

Type of notice:	Must be issued:	Timing of notice:	Optional/Voluntary use:
Financial liability notice	• Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice, HHA, and RNHCI providers only) but may not be paid for in this particular case because it is not considered medically reasonable and necessary • Prior to providing custodial care • For hospice providers, prior to caring for a patient who is not terminally ill • For DME suppliers, additional situations requiring issuance are outlined in 50.3.1 • For HHA providers, prior to providing care when the individual is not confined to the home or does not need intermittent skilled nursing care.	Prior to delivery of the item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.	Yes. Prior to providing an item or service that is never covered by Medicare (not a Medicare benefit).

50.1 - General Statutory Authority - Financial Liability Protection Provisions (FLP) of Title XVIII (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Medicare Appeals and Denials

The Financial Liability Protection provisions (FLP) of the Social Security Act (the Act) protect beneficiaries, health care providers and suppliers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. The FLP provisions include:

[1] This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 50.

- Limitation On Liability (LOL) under §1879(a)-(g) of the Act;

- Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l) of the Act; and

- Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act.

Additional information on the FLP provisions can be found in Sections 10 and 20 of this chapter.

50.2.1 - Applicability to Limitation On Liability (LOL)
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

The Limitation On Liability (LOL) protections of §1879 of the Act apply only when a provider believes that a Medicare covered item or service may be denied in a particular instance because it is not reasonable and necessary under §1862(a)(1) of the Act or because the item or service constitutes custodial care under §1862(a)(9) of the Act. §1879 of the Act requires a provider to notify a beneficiary in advance when s/he believes that items or services will likely be denied either as not reasonable and necessary or as constituting custodial care. If such notice (in the form of an ABN or as otherwise noted in
§40.2) is not given, providers may not shift financial liability to beneficiaries for these items or services if Medicare denies the claim. Beneficiaries are afforded LOL protection when items or services are denied for reasons listed in §50.3.1.

50.2.2 - Compliance with Limitation On Liability Provisions
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A healthcare provider/supplier (herein also referred to as a “notifier”) who fails to comply with the ABN instructions risks financial liability and/or sanctions. LOL provisions shall apply as required by law, regulations, rulings and program instructions. Additionally, when authorized by law and regulations, sanctions under the Conditions of Participation (COPs) may be imposed.

The Medicare contractor will hold any provider who either failed to give notice when required or gave defective notice financially liable. A notifier who can demonstrate that s/he did not know and could not reasonably have been expected to know that Medicare would not make payment will not be held financially liable for failing to give notice.
However, a notifier who gave defective notice may not claim that s/he did not know or could not reasonably have been expected to know that Medicare would not make payment as the issuance of the notice (albeit defective) is clear evidence of knowledge. See §50.12 for Refund Requirements.

50.3 - ABN Scope
(Rev. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14)

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and certain care provided under Part A (hospice and religious non-medical healthcare institutes only). With the exception of DME POS suppliers (see Section 50.10), providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries.

Provider use of the ABN has expanded to include home health agency (HHA) issuance for Part A and Part B items and services. The ABN will replace the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1 issued by HHAs. The mandatory date for HHAs to use the ABN instead of the HHABN, Option Box 1 will be posted on the web link for home health notices found at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html. Information specific to HHA use of the ABN has been added in §50.15.4. The guidelines for ABN use published in this section and the ABN form instructions apply to HHAs unless noted otherwise.

The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The ABN is used to fulfill both mandatory and voluntary notice functions.

The ABN replaces the following notices:

- ABN-G (CMS-R-131-G)
- ABN-L (CMS-R-131-L)
- NEMB (CMS-20007)
- Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296, Option Box 1 (effective 2013)

Skilled Nursing Facilities (SNFs) issue the ABN for Part B services only. The Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), CMS Form 10055, is issued for Part A SNF items and services. Section 70 of this chapter contains information on SNFABN issuance.

50.3.1 - Mandatory ABN Uses
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

The following provisions necessitate delivery of the ABN:

- §1862(a)(1) of the Act (not reasonable and necessary);

- §1834(a)(17)(B) of the Act (violation of the prohibition on unsolicited telephone contacts);

- §1834(j)(1) of the Act (medical equipment and supplies supplier number requirements not met);

- §1834(a)(15) of the Act (medical equipment and/or supplies denied in advance);

- §1862(a)(9) of the Act (custodial care);

- §1879(g)(2) of the Act (hospice patient who is not terminally ill); or

- §1879(g)(1) of the Act (home health services requirements are not met – not confined to the home or no need for intermittent skilled nursing care).

- §1833(g)(5) of the Act (when outpatient therapy services are in excess of therapy cap amounts and don't qualify for a therapy cap exception – effective January 1, 2013).

When Medicare considers an item or service experimental (e.g., a "Research Use Only" or "Investigational Use Only" laboratory test), payment for the experimental item or service is denied under §1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

Expanded mandatory ABN use in 2011

The Patient Protection and Affordable Care Act, P.L. 111-148, §4103(d)(1)(C) added a new subparagraph (P) to 1862(a)(1)of the Act. Per §1862(a)(1)(P), Medicare covered personalized prevention plan services (as defined in section 1861(hhh)(1)) that are performed more frequently than indicated per coverage guidelines are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The LOL provisions of §1879 apply to this new subparagraph; thus, providers must issue an ABN prior to providing a preventative service that is usually covered by Medicare but will not be covered in this instance because frequency limitations have been exceeded.

In addition, delivery of an ABN is mandatory under 42 CFR §414.408(e)(3)(ii) when a noncontract supplier furnishes an item included in the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) for a Competitive Bidding Area (CBA). Although all other denial reasons triggering mandatory use of the ABN are found in §1879 of the Act, in this situation,
§1847(b)(5)(D) of the Act permits use of the ABN with respect to these items and services.

50.3.2 - Voluntary ABN Uses
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

ABNs are not required for care that is either statutorily excluded from coverage under Medicare

(i.e. care that is never covered) or most care that fails to meet a technical benefit requirement (i.e. lacks required certification). However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

- Care that fails to meet the definition of a Medicare benefit as defined in §1861 of the Social Security Act;

- Care that is explicitly excluded from coverage under §1862 of the Social Security Act. Examples include:

  - Services for which there is no legal obligation to pay;
  - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
  - Services required as a result of war;
  - Personal comfort items;
  - Routine eye care;
  - Dental care; and
  - Routine foot care.

The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation. When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice. The provider or supplier is not required to adhere to the issuance guidelines for the mandatory notice (as set forth below) when using the ABN for voluntary notification.

Note: Certain DME items/services that fail to meet a technical requirement may require an ABN as outlined in the mandatory use section above.

50.4 - Issuance of the ABN
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.4.1 - Issuers of ABNs (Notifiers)
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Entities who issue ABNs are collectively known as "notifiers". These entities can include physicians, practitioners, providers (including laboratories), and suppliers, and/or utilization review committees for the care provider. In 2013, HHAs are added as ABN issuers.

The notifier may direct an employee or a subcontractor to deliver an ABN. The billing entity will always be held responsible for effective delivery regardless of who gives the notice. When multiple entities are involved in rendering care, it is not necessary to give separate ABNs. Either party involved in the delivery of care can be the notifier when:

- There are separate "ordering" and "rendering" providers (e.g. a physician orders a lab test and an independent laboratory delivers the ordered tests);

- One provider delivers the "technical" and the other the "professional" component of the same service (e.g. a radiological test that an independent diagnostic testing facility renders and a physician interprets); or

- The entity that obtains the signature on the ABN is different from the entity that bills for services (e.g. when one laboratory refers a specimen to another laboratory which then bills Medicare for the test).

When the notifier is not the billing entity, the notifier must know how to direct the beneficiary who received the ABN to the billing entity for questions and should annotate the Additional Information section of the ABN with this information. It is permissible to enter the names of more than one entity in the header of the notice.

50.4.2.-Recipients of the ABN
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Notifiers are required to give an ABN to a FFS Medicare beneficiary or his/her representative before providing him/her with a Medicare covered item or service that may not be covered in this particular instance or before providing custodial care. Recipients of ABNs include beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). A notifier's inability to give notice to a beneficiary or his/her representative does not allow the notifier to shift financial liability to the beneficiary.
Note: See §§40.3.4.6 and 50.6.5.B in this chapter for information on beneficiary refusals.

50.4.3 - Representatives of Beneficiaries
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Notifiers are responsible for determining who may act as a beneficiary's authorized representative for the purposes of ABN issuance under applicable State or other law. An individual who may make health care and financial decisions on a beneficiary's behalf (e.g. the beneficiary's legal guardian or someone appointed according to a properly executed "durable medical power of attorney") is an authorized representative. If the beneficiary has a known, legally authorized representative, the ABN must be issued to the existing representative. If a beneficiary does not have a representative and one is necessary, a representative may be appointed for purposes of receiving notice following CMS guidelines and as permitted by State and Local law. See §40.3.5 of this chapter for more detailed guidance on representatives.

When a representative is signing the ABN on behalf of a beneficiary, the ABN should be annotated to identify that the signature was penned by the "rep" or "representative". If the representative's

signature is not clearly legible, the representative's name should be printed on the ABN.

50.5 - ABN Triggering Events
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Notifiers are required to issue ABNs when an item or service is expected to be denied based on one of the provisions in §50.3.1. This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as "triggering events".

A. Initiations

An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment. If a notifier believes that certain otherwise covered items or services will be noncovered (e.g. not reasonable and necessary) at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.

Example: Mrs. S. asks her physician for an EKG because her sister was recently diagnosed with atrial fibrillation. Mrs. S. has no diagnosis that warrants medical necessity of an EKG but insists on having an EKG even if she has to pay out of pocket for it. The physician's office personnel issue an ABN to Mrs. S. before the EKG is done.

B. Reductions

A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.). The ABN is not issued every time an item or service is reduced. But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this noncovered care.

Example: Mr. T , is receiving outpatient physical therapy five days a week, and after meeting several goals, therapy is reduced to three days per week. Mr. T wants to achieve a higher level of proficiency in performing goal related activities and wants to continue with therapy 5 days a week. He is willing to take financial responsibility for the costs of the 2 days of therapy per week that are no longer medically reasonable and necessary.
An ABN would be issued prior to providing the additional days of therapy weekly.

C. Terminations

A termination is the discontinuation of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

Example: Ms. X has been receiving covered outpatient speech therapy services, has met her

treatment goals, and has been given speech exercises to do at home that do not require therapist intervention. Ms. X wants her speech therapist to continue to work with her even though continued therapy is not medically reasonable or necessary. Ms. X is issued an ABN prior to her speech therapist resuming therapy that is no longer considered medically reasonable and necessary.

50.6 - ABN Standards
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.6.1 - Proper Notice Documents
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

The ABN, Form CMS-R-131, is the Office of Management and Budget (OMB) approved standard notice. Failure to use this notice as mandated could result in the notice being invalidated and/or the notifier being held liable for the items or services in question.

The online replicable copies of the OMB approved ABN (CMS-R-131) and instructions for notice completion are available on the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

A. Language Choice

The ABN is available in English and Spanish under a dedicated link on the web page given above. Notifiers should choose the appropriate version of the ABN based on the language the beneficiary best understands. Insertions must be in English when the English language ABN is used. Similarly, when a Spanish language ABN is used, the notifier should make insertions on the notice in Spanish, if applicable. In addition, verbal assistance in other languages may be provided to assist beneficiaries in understanding the document. However, the printed document is limited to the OMB-approved English and Spanish versions. Notifiers should document any types of translation assistance that are used in the “Additional Information” section of the notice.

B. Effective Versions

ABNs are effective as of the OMB approval date given at the bottom of each notice. The routine approval is for 3-year use. Notifiers are expected to exclusively use the current version of the ABN. Providers/suppliers must be attentive to the OMB approval date on the notice and seek instruction from the CMS website http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html on obtaining current versions of notices. CMS will allow a transition period for providers and suppliers to switch from using expiring notices to newly approved notices. The date of mandatory use of newly approved notices will be announced on the CMS website with the notice’s release.

50.6.2 - General Notice Preparation Requirements
(Rev. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14)

The following are the general instructions that notifiers must follow in preparing an ABN for mandatory use:

A. **Number of Copies:** A minimum of two copies, including the original, must be made so the beneficiary and notifier each have one. The notifier should retain the original whenever possible.

B. **Reproduction**: Notifiers may reproduce the ABN by using self-carbonizing paper, photocopying, digitized technology, or another appropriate method. All reproductions must conform to applicable form and manual instructions.

C. **Length and Size of Page:** The ABN form must not exceed one page in length; however, attachments are permitted for listing additional items and services. If attachments are used, they must allow for clear matching of the items or services in question with the reason and cost estimate information. The ABN is designed as a letter- sized form. If necessary, it may be expanded to a legal-sized page.

D. **Contrast of Paper and Print:** A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (i.e. white print on black paper), or block-shaded (highlighted) text.

E. **Font:** To the extent practicable, the fonts as they appear in the ABN downloaded from the CMS web site should be used. Any changes in the font type must be based solely on limitations of the notifier's software and/or hardware. In such cases, notifiers should use alternative fonts that are easily readable, such as Arial, Arial Narrow, Times New Roman, and Courier. Font style and formatting must be maintained regardless of font type used.

Any other changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the ABN more difficult to read. The font size generally should be 12 point. Titles should be 14-16 point, but insertions in blanks of the ABN can be as small as 10 point if needed.

Information inserted by notifiers in the blank spaces on the ABN may be typed or legibly hand-written.

F. **Customization:** Notifiers are permitted to do some customization of ABNs, such as pre-printing information in certain blanks to promote efficiency and to ensure clarity for beneficiaries. Notifiers may develop multiple versions of the ABN specialized to common treatment scenarios, using the required language and general formatting of the ABN. Blanks (G)-(I) must be completed by the beneficiary or his/her representative when the ABN is issued and may **never** be pre-filled. Lettering of the blanks (A-J) should be removed prior to issuance of an ABN.

If pre-printed information is used to describe items/services and/or common reasons for noncoverage, the notifier must clearly indicate on the ABN which portions of the pre- printed

information are applicable to the beneficiary. For example, pre-printed items or services that are inapplicable may be crossed out, or applicable items/services may be checked off.

Providers who pre-print a menu of items or services may wish to list a cost estimate alongside each item or service. For example, notifiers may merge the items/service section (Blank D) with the estimated cost section (Blank F) as long as the beneficiary can clearly identify the services and related costs that may not be covered by Medicare.

G. Modification: The ABN may not be modified except as specifically allowed by these instructions.

Notifiers must exercise caution before adding any customizations beyond these guidelines, since changing ABNs too much could result in invalid notice and provider liability for noncovered charges. Validity judgments are generally made by Medicare contractors, usually when reviewing ABN-related claims; however, any complaints received may be investigated by contractors and/or CMS central or regional offices.

An example of an approved customization of the ABN which can be used by providers of laboratory services (Sample Lab ABN) is available for download http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

50.6.3 - Completing the ABN
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Step by step instructions for notice completion are posted along with the notice on the CMS website and can be downloaded via this link: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Notifiers must follow guidance provided in this section and the instructions posted on the CMS website to construct a valid notice.

50.6.4 – Retention Requirements
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

The ABN must be prepared with an original and at least one copy. The beneficiary is given his/her copy of the signed and dated ABN immediately, and the notifier should retain the original ABN in the beneficiary's record. In certain situations, such as delivery by fax, the notifier may not have access to the original document upon signing. Retention of a copy of the signed document would be acceptable in specific cases such as this.

In a case where the notifier that gives an ABN is not the entity that ultimately bills Medicare for the item or service (e.g. when a physician issues an ABN, draws a test specimen, and sends it to a laboratory for testing), the notifier must give a copy of the signed ABN to the billing entity. The

copy provided must be legible and may be a carbon, fax, electronically scanned, or photo reproduction copy.

Applicable retention periods for the ABN are discussed in Chapter 1 of this manual, §110. In general, it is 5 years from discharge/completion of delivery of care when there are no other applicable requirements under State law. Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice. Electronic retention of the signed paper document is acceptable. Notifiers may scan the signed paper or "wet" version of the ABN for electronic medical record retention and if desired, give the paper copy to the beneficiary.

50.6.5 - Other Considerations During ABN Completion (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Changes His/Her Mind

If after completing and signing the ABN, a beneficiary changes his/her mind, the notifier should present the previously completed ABN to the beneficiary and request that the beneficiary annotate the original ABN. The annotation must include a clear indication of his/her new option selection along with the beneficiary's signature and date of annotation. In situations where the notifier is unable to present the ABN to the beneficiary in person, the notifier may annotate the form to reflect the beneficiary's new choice and immediately forward a copy of the annotated notice to the beneficiary to sign, date, and return.

In both situations, a copy of the annotated ABN must be provided to the beneficiary as soon as possible. If a related claim has been filed, it should be revised or cancelled if necessary to reflect the beneficiary's new choice.

B. Beneficiary Refuses to Complete or Sign the Notice

If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the notifier should annotate the original copy of the ABN indicating the refusal to sign or choose an option and may list witness(es) to the refusal on the notice although this is not required. If a beneficiary refuses to sign a properly delivered ABN, the notifier should consider not furnishing the item/service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option.

In any case, the notifier must provide a copy of the annotated ABN to the beneficiary, and keep the original version of the annotated notice in the patient's file.

50.7 - ABN Delivery Requirements (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.7.1 - Effective Delivery
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Delivery Requirements

ABN delivery is considered to be effective when the notice is:

1. Delivered by a suitable notifier to a capable recipient and comprehended by that recipient.
2. Provided using the correct OMB approved notice with all required blanks completed.

   Failure to use the correct notice may lead to the notifier being found liable since the burden of proof is on the notifier to show that knowledge was conveyed to the beneficiary according to CMS instructions.

3. Delivered to the beneficiary in person if possible.

4. Provided far enough in advance of delivering potentially noncovered items or services to allow sufficient time for the beneficiary to consider all available options.

5. Explained in its entirety, and all of the beneficiary's related questions are answered timely, accurately, and completely to the best of the notifier's ability.

   The notifier should direct the beneficiary to call 1-800-MEDICARE if the beneficiary has questions s/he cannot answer. If a Medicare contractor finds that the notifier refused to answer a beneficiary's inquiries or direct them to 1-800-MEDICARE, the notice delivery will be considered defective, and the notifier will be held financially liable for noncovered care.

6. Signed by the beneficiary or his/her representative.

B. Period of Effectiveness/ Repetitive or Continuous Noncovered Care

An ABN can remain effective for up to one year. Notifiers may give a beneficiary a single ABN describing an extended or repetitive course of noncovered treatment provided that the ABN lists all items and services that the notifier believes Medicare will not cover. If applicable, the ABN must also specify the duration of the period of treatment. If there is any change in care from what is described on the ABN within the 1- year period, a new ABN must be given. If during the course of treatment additional noncovered items or services are needed, the notifier must give the beneficiary another ABN. There is a one year limit for using a single ABN for an extended course of treatment. A new ABN is required when the specified treatment extends beyond one year.

If a beneficiary is receiving repetitive non-covered care, but the provider or supplier failed to issue an ABN before the first or the first few episodes of care were provided, the ABN may be issued at any time during the course of treatment. However, if the ABN is issued after repetitive treatment has been initiated, the ABN cannot be retroactively dated or used to shift liability to the beneficiary for care that had been provided before ABN issuance. In cases such as this, care that was provided before ABN delivery would be the financial responsibility of the supplier/provider.

C. Incomplete ABNs

Allegations of improper or incomplete notices will be investigated by Medicare contractors. If the notifier is found to have given improper or incomplete written notice, the applicable Medicare contractor will not hold the beneficiary liable in the individual case.

D. Electronic Issuance of the ABN

Electronic issuance of ABNs is not prohibited. If a provider elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what s/he prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed ABN to keep for his/her own records. As stated earlier in §50.6.4, electronic retention of the signed ABN is permitted.

50.7.2 - Options for Delivery Other than In-Person (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

ABNs should be delivered in-person and prior to the delivery of medical care which is presumed to be noncovered. In circumstances when in-person delivery is not possible, notifiers may deliver an ABN through one of the following means:

- Direct telephone contact;
- Mail;
- Secure fax machine; or
- Internet e-mail

All methods of delivery require adherence to all statutory privacy requirements under HIPAA. The notifier must receive a response from the beneficiary or his/her representative in order to validate delivery.

When delivery is not in-person, the notifier must verify that contact was made in his/her records. In order to be considered effective, the beneficiary should not dispute such contact. Telephone contacts must be followed immediately by either a hand-delivered, mailed, emailed, or faxed notice. The beneficiary or representative must sign and retain the notice and send a copy of this signed

notice to the notifier for retention in the patient's record.

The notifier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the notifier must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself.

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Liability

A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.

Notifiers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.13 for information on collection of funds.

B. Provider Liability

A notifier will likely have financial liability for items or services if s/he knew or should have known that Medicare would not pay and fails to issue an ABN when required, or issues a defective ABN. In these cases, the notifier is precluded from collecting funds from the beneficiary and is required to make prompt refunds if funds were previously collected. Failure to issue a timely refund to the beneficiary may result in sanctions.

A notifier may be protected from financial liability when an ABN is required if s/he is able to demonstrate that s/he did not know or could not reasonably have been expected to know that Medicare would not make payment. However, issuance of a defective notice establishes the notifier's knowledge of potential noncoverage, and will not afford the notifier financial protection under the LOL or refund provisions.

HHAs: Please see 50.15.4 for additional information specific to HHA claim determinations and liability.

50.7.3.1 - Using ABNs for Medical Equipment and Supplies Claims When Denials Under §1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts) Are Expected (Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(a)(18) or §1879(h)(3) of the Act (unassigned and assigned claims, respectively), an ABN must clearly identify the particular item or service and state that the supplier expects that Medicare will deny payment for that particular medical equipment or supplies because the supplier violated the prohibition on unsolicited telephone contacts. The supplier must obtain a signed ABN before furnishing the item to the beneficiary. Since it is the unsolicited telephone contact which is prohibited by law, giving advance beneficiary notice by telephone does not qualify as notice and is not permissible. Telephone notice may not be used in this case.

The contractor will not accept any telephone ABN as effective notice to the beneficiary. Since giving or mailing a written ABN and obtaining the beneficiary's agreement to pay before telephoning is equivalent to obtaining the beneficiary's written permission for the supplier to telephone under §1834(a)(17)(A)(i) of the Act, a supplier has little to gain from using the ABN process instead of simply seeking the beneficiary's written permission to contact him or her. If a supplier does use a written ABN prior to calling,

the beneficiary's agreement to pay is essential under the Refund Requirements in order for the supplier to collect from the beneficiary. Medicare denial of payment because of the prohibition on unsolicited telephone contacts applies to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally. Therefore, the usual restriction on routine notices to all beneficiaries does not apply in this case. (See
§40.3.6.4.D, "Routine ABN Prohibition Exceptions.")

50.7.3.2 - ABNs for Medical Equipment and Supplies Claims Denied Under §1834(j)(1) of the Act (Because the Supplier Did Not Meet Supplier Number Requirements)
(Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(j)(4)(A) and §1879(h)(1) of the Act (unassigned and assigned claims, respectively) for medical equipment and supplies for which payment will be denied due to failure to meet supplier number requirements under §1834(j)(1) of the Act, the ABN must state that Medicare will deny payment for any medical equipment or supplies because the supplier does not have a supplier number. The ABN must convey to the beneficiary the certainty of denial, so that the beneficiary can make an informed consumer decision whether to receive the medical equipment or supplies and pay for it out of pocket. The following is acceptable language for the ABN-G "Because:" box: "Medicare will pay for items furnished to you by a supplier of medical equipment and supplies only if the supplier has a Medicare supplier number. Payment for such items furnished to you by a supplier which does not have a supplier number is prohibited under the Medicare law. We do not have a Medicare supplier number, therefore, Medicare will not pay for any medical equipment and supplies which we furnish to you." It is particularly important that the beneficiary's signed agreement to pay should be dated by the beneficiary because, in this type of denial, any proper written advance notice with the beneficiary's signed agreement to pay shall be effective for any medical equipment or supplies purchased or rented from the same supplier within

the one year following the date of the beneficiary's signed agreement to pay. This exception relieves the supplier, which has duly notified a beneficiary of its lack of a supplier number and the fact that Medicare will not pay, from the necessity of obtaining a signed agreement from the beneficiary every time the beneficiary does business with the supplier.

Exception to ABN Requirement

A supplier which can show that it did not know and could not reasonably have been expected to know that a customer was a Medicare beneficiary, or that a customer was making a purchase for a Medicare beneficiary, can seek protection under the LOL provision, §1879 of the Act, or, in the case of unassigned claims, under the applicable RR provision, §1834(j)(4) of the Act. If the supplier can show that a person who is not a Medicare beneficiary made a purchase on behalf of a person who is a Medicare beneficiary and did not apprise the supplier of the fact that the purchase was being made on behalf of a Medicare beneficiary, the supplier may be protected. If the supplier can show that a Medicare beneficiary who made a purchase did not identify himself or herself as a Medicare beneficiary and that the person's age or appearance was such that the supplier could not reasonably have been expected to know or surmise that the person was a Medicare beneficiary, the supplier may be protected. These protections are meant for an honest supplier in the rare case where a Medicare beneficiary who is relatively youthful, healthy and able in appearance does not identify himself or herself as a beneficiary and the supplier understandably does not surmise that he or she might be a Medicare beneficiary. If the beneficiary disputes the supplier's allegation and conclusive proof of the allegation is not presented, the supplier's allegation may not be accepted. If the involved Medicare beneficiary is found to be obviously aged and/or disabled, such that any adult person working for a supplier would reasonably surmise that he or she could be a Medicare beneficiary, the supplier's allegation may not be accepted. If the beneficiary purchased an item which would strongly suggest to any reasonable adult person working for a supplier that the beneficiary is aged and/or disabled, the supplier's allegation may not be accepted. If a supplier can show that a customer, who is a Medicare beneficiary or was making a purchase for a Medicare beneficiary and did not identify him/herself accordingly to the supplier, was on notice of the necessity to so self-identify, the beneficiary may be held liable under §1879 or §1834(j)(4) of the Act, in which case the supplier could collect from the beneficiary. Given the possible difficulty of showing conclusively that it did not know and could not reasonably have been expected to know that a customer was a Medicare beneficiary, or that a customer was making a purchase for a Medicare beneficiary, a supplier would be well advised to consider using signage, giving public notice alerting customers that they need to inform the supplier if they are a Medicare beneficiary or are making a purchase for a Medicare beneficiary. If a supplier which does not have a supplier number provides adequate public notice to a Medicare beneficiary before medical equipment or supplies are furnished, e.g., by means of clearly visible signs, and if the adequacy of such public notice is not disputed by the beneficiary, the supplier can qualify for waiver of the Refund Requirements. Such public notices must be such that Medicare beneficiaries:

1. Are virtually certain to see them before purchasing or renting Medicare-covered medical equipment or supplies from the supplier (that is, they are posted in places where they are

most likely to be seen by the target audience), and

2. May reasonably be expected to be able to read them and understand them.

Therefore, such public notices must be readily visible, in easily readable plain language, in large print, and would have to be provided in the language(s) commonly used in the locality. The following is acceptable language for the public notice:

Notice to Medicare Beneficiaries. Medicare will pay for medical equipment and supplies only if a supplier has a Medicare supplier number. We do not have a Medicare supplier number. Medicare will not pay for any medical equipment and supplies we sell or rent to you. You will be personally and fully responsible for payment.

Do not hold any beneficiary who cannot read any such public notice of a supplier to be properly notified in advance by the supplier that Medicare will not pay. If a supplier alleges that it provided adequate public notice to Medicare beneficiaries but a beneficiary disputes the allegation, in the absence of conclusive evidence in favor of the supplier, do not hold the beneficiary to be properly notified in advance by the supplier that Medicare will not pay; hold the supplier liable. The RR provision that the beneficiary must agree to pay for the item or service makes the use of signage without an ABN a risk for the supplier. It would be in a supplier's best interest to issue ABNs advising beneficiaries that they will have to pay for supplies and to post public notices in its store(s) which inform beneficiaries of the fact that it is not a Medicare enrolled supplier, and that claims for supplies purchased from that supplier will be denied payment by Medicare.

Medicare denial of payment on the basis of a supplier's lack of a supplier number applies to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally. Therefore, the usual restriction on routine notices to all beneficiaries does not apply in this case. (See §40.3.6.4.D, "Routine ABN Prohibition Exceptions.") Given the potential for beneficiary disputes over suppliers' public notice efforts to result in supplier liability, all suppliers which do not have supplier numbers would be very well advised to provide the standard written ABN to all Medicare beneficiaries, obtaining their signed agreement. The use of written notices in conjunction with public notices will provide maximum protection to suppliers as well as more surely providing proper advance notice to beneficiaries so that they can make informed consumer decisions.

50.7.3.3 - ABNs for Medical Equipment and Supplies Claims Denied in Advance Under §1834(a)(15) of the Act - Prior Authorization Procedures (Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(j)(4)(B) and §1879(h)(2) of the Act (unassigned and assigned claims, respectively) for medical equipment and supplies for which payment is denied in advance under §1834(a)(15) of the Act, the ABN-G must clearly identify the particular item of medical equipment and supplies and must state in the "Because:" box either:

"Medicare has denied payment in advance and we expect that Medicare will continue to deny payment." or "Medicare requires that we request an advance determination of coverage of this medical equipment and/or supplies. We have not requested an advance determination, so we expect that Medicare will deny payment." as applicable. Denial of payment in advance under §1834(a)(15) of the Act refers both to cases in which the supplier requested an advance determination and you determined that the item would not be covered, and to cases in which the supplier failed to request an advance determination when such a request is mandatory. (See §150.5.2, "Knowledge Standards for §1834(a)(15) Denials.")

50.8 - ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Notifiers must give an ABN before a beneficiary receives a Medicare covered item containing upgrade components that are not medically reasonable and necessary and not paid for by the supplier. For example, an ABN must be issued when a notifier expects that Medicare will not pay for additional parts or features of a usually covered item because those parts and/or features are not medically reasonable and necessary. DME upgrades involve situations in which the upgraded item or component has a different Heath Insurance Common Procedure Coding System (HCPCS) code than the item that will be covered by Medicare. Please refer to Chapter 20, Section 120 in this manual for information on billing procedures for ABN upgrades.

ABNs cannot be used to charge beneficiaries for premium quality services described as "excess components." Similarly, ABNs cannot be used to shift liability for an item or service that is described on the ABN as being "better" or "higher quality" on an ABN but do not exceed the HCPCS code description.

50.9 - ABNs for Denials Under §1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts)
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A refund is required under §1834(a)(18) or §1879(h)(3) of the Act for both assigned and unassigned claims unless prior to furnishing the item, a valid ABN was issued notifying the beneficiary of potential nonpayment because the supplier violated the prohibition against unsolicited telephone contacts. The supplier must obtain a signed ABN before furnishing the item to the beneficiary.

Giving advance beneficiary notice by telephone does not qualify as notice in this case and is not permissible. The supplier must either hand deliver or mail a written ABN and obtain the beneficiary's signature prior to making the unsolicited telephone contact.

Since unsolicited telephone contacts are expressly prohibited by statute, there is presumption of supplier knowledge of this provision. To rebut this presumption, the supplier must submit

convincing evidence showing ignorance of the prohibition. A previous denial of a claim for any item furnished by a particular supplier on the basis of this prohibition is considered actual notice to that supplier. Such a denial shall be construed as actual knowledge on all future claims.

50.10 - ABNs for Claims Denied Under §1834(j)(1) of the Act (Supplier Did Not Meet Supplier Number Requirements)
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Sections 1834(j)(4)(A) and 1879(h)(1) of the Act require issuance of a valid ABN notifying the beneficiary of potential nonpayment because a supplier did not meet the supplier number requirement. These provisions apply to both assigned and unassigned claims.

Suppliers without a Medicare supplier number have the option of giving public notice to beneficiaries regarding their Medicare status in lieu of issuing individual ABNs to all Medicare beneficiaries. The supplier can qualify for a waiver of the refund requirements if adequate public notice is given to beneficiaries informing them of the supplier's failure to meet Medicare's supplier number requirements as long as the adequacy of such public notice is not disputed by the beneficiary. An example of adequate public notice would include clearly visible signs posted at the supplier's place of business. If a supplier only conducts business via the internet, a clearly visible notice on the supplier's internet business site is acceptable as long as such notice is also available in printed materials, such as a supplier's catalog. These public notices must be readily visible, in easily readable plain language, in large print, and must be provided in the language(s) commonly used in the locality.

In the event that the beneficiary disputes receipt of public notice, there is a presumption that the supplier did not properly notify the beneficiary unless the supplier can provide evidence to the contrary. Medicare contractors will not hold a beneficiary who cannot read any such public notice liable.

If a supplier can show that s/he did not know that a purchase was being made either by or for a Medicare beneficiary, s/he may seek protection from the refund requirements under §1834(j)(4) of the Act.

Medicare contractors presume that suppliers know that a supplier number is required in order for Medicare to make payment. Thus, a supplier would have to submit evidence to the contrary to rebut this presumption. However, this presumption is not rebuttable if a supplier has previously received a claim denial §1834(j)(1).

50.11 - ABNs for Claims Denied in Advance Under §1834(a)(15) of the Act (When a Request for an Advance Determination of Coverage Is Mandatory)
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

50.11.1 - Situations In Which Advance Coverage Determinations Are Mandatory

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A request for an advance determination of coverage of medical equipment and supplies is mandatory under §1834(a)(15)(C)(i) & (ii) of the Act when:

- The item is listed by the Secretary as being subject to unnecessary utilization in your contractor's service area under §1834(a)(15)(A); or

- The supplier is listed by the Secretary under §1834(a)(15)(B) of the Act as a supplier who has submitted a substantial number of claims, which have been denied as not medically reasonable and necessary under §1862(a)(1) of the Act or the Secretary has identified a pattern of over utilization.

In cases in which an advance coverage determination is mandatory, an ABN must be issued to the beneficiary prior to furnishing the item. If the advance coverage determination has not been received, or if the determination is that Medicare will not pay for the care, an ABN is required prior to furnishing the requested item.

50.11.2 - Situations In Which Advance Coverage Determinations Are Optional (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

A request for an advance determination of coverage of medical equipment and supplies is optional under §1834(a)(15)(C)(iii) of the Act when the item is customized and either the patient or the supplier requests an advance determination. In cases where an advance coverage determination is optional and the beneficiary requests such a determination, an ABN must be furnished prior to furnishing the requested item.

Every supplier is expected to know whether or not an advance coverage determination is required for Medicare payment. The presumption of that supplier's knowledge becomes non-rebuttable after a single denial under §1834(a)(15) of a claim by a particular supplier.

50.12 - ABNs for items listed in a DMEPOS Competitive Bidding Program (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

§1862 (a)(17) excludes Medicare payment for Competitive Bidding Program (CBP) items/ services that are provided by a non-contract supplier in a Competitive Bidding Area (CBA) except in special circumstances. A non-contracted supplier is permitted to provide a beneficiary with an item or service listed in the CBP when the supplier properly issues an ABN prior to delivery of the item or service per 42 CFR §414.408(e)(3)(ii). In order for the ABN to be considered valid when issued under these circumstances, the reason that Medicare may not pay must be clearly and fully explained on the ABN that is signed by the beneficiary.

Sample wording for the "Reason Medicare May Not Pay" blank of the ABN:
Since we are not a contracted supplier, Medicare will not pay for this item. If you get this item from a contracted supplier such as ABC Medical Supplies, Medicare will pay for it.

To be a valid ABN, the beneficiary must understand the meaning of the notice. Suppliers must explain to the beneficiary that Medicare will pay for the item if it is obtained from a different supplier in the area. While some suppliers may be reluctant to direct beneficiaries to a specific contracted supplier, the non-contracted supplier should at least direct the beneficiary to 1-800 –MEDICARE to find a local contracted supplier at the beneficiary's request.

50.13 - Collection of Funds and Refunds (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Collection of Funds

A beneficiary's agreement to be responsible for payment on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare that the beneficiary may have. The notifier may bill and collect funds from the beneficiary for noncovered items or services immediately after an ABN is signed, unless prohibited from collecting in advance of the Medicare payment determination by other applicable Medicare policy, State or local law. Regardless of whether they accept assignment or not, providers and suppliers are permitted to charge and collect the usual and customary fees; therefore, funds collected are not limited to the Medicare allowed amounts.

If Medicare ultimately denies payment of the related claim, the notifier retains the funds collected from the beneficiary unless the claim decision finds the provider/supplier liable. When Medicare finds the provider/supplier liable or if Medicare or a secondary insurer subsequently pays all or part of the claim for items or services previously paid by the beneficiary to the notifier, the notifier must refund the beneficiary the proper amount in a timely manner.

B. Refund Requirements Requiring Liability Notice

Under the Refund Requirements in §§1842(l) and 1879(h) of the Act, a beneficiary must receive a properly executed ABN so that he or she is "on notice" of liability. By signing the ABN, the beneficiary acknowledges that s/he understands the potential for liability and agrees to pay for the item or service described. The refund requirements requiring ABNs are:

1. Supplier claims under §1879(h) of the Act, citing three specific requirements when assignment is accepted:

    a. §1834(j)(1), when supplier number requirements for medical equipment and supplies are not met;

b. §1834(a)(15), when medical equipment and/or supplies are denied in advance; or

c. §1834(a)(17)(B), when there is a violation of the prohibition on unsolicited telephone contacts for medical equipment and supplies.

2. Physician claims under §1842(l) from non-participating physicians when assignment is not accepted for individual items and services that are denied on the basis of §1862(a)(1).

Physicians must make prompt refunds unless they could not have been expected to know that Medicare would not provide coverage or they notified the beneficiary in advance by issuing the ABN. Refunds are considered prompt when made within 30 days of notice of denial from Medicare or within 15 days after a determination on an appeal if an appeal is made.

50.13.1 - Physicians' Services Refund Requirements
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

The physicians' services refund requirement provision, found in §1842(l) of the Act as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1986, requires timely refunds for certain services. When a reduction in payment, not a full denial, occurs, the physician must refund to the beneficiary amounts collected which exceed the Medicare payment for the less extensive item or service. These refund requirements apply to both participating and non-participating physicians.

When the beneficiary signs an ABN agreeing to accept responsibility for payment before services are delivered, the collected funds can be retained. A refund is not required if the physician did not know and could not reasonably have been expected to know that Medicare would not pay for the services because they were not reasonable and necessary.

The Medicare contractor must notify the beneficiary in any case in which the physician requests review of the denial or reduction in payment or asserts that a refund is not required.

50.13.2 - DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

All suppliers who sell or rent medical equipment and supplies to Medicare beneficiaries are subject to the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act, whether accepting assignment or not. Medical equipment and supplies are defined in the following statutes applicable to this section:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;

- Surgical dressings, as described in §1861(s)(5) of the Act;
- Home dialysis supplies and equipment, as described in §1861(s)(2)(F) of the Act;
- Immunosuppressive drugs, as described in §1861(s)(2)(J) of the Act;
- Therapeutic shoes for diabetics, as described in §1861(s)(12) of the Act;
- Oral drugs prescribed for use as an anticancer therapeutic agent, as described in §1861(s)(2)(Q) of the Act;
- Self-administered erythropoietin, as described in §1861(s)(2)(P) of the Act; and
- Other items as determined by the Secretary.

If a proper ABN is not issued prior to the receipt of one of the preceding items and the above provisions apply, the beneficiary has no financial responsibility. The refund provisions of the Act apply to both assigned and unassigned claims.

50.13.3 - Time Limits and Penalties for Physicians and Suppliers in Making Refunds (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A required refund must be made within specified time limits:

- The refund must be made to the beneficiary within 30 days after the date the physician/supplier receives the remittance advice (RA) if the physician/supplier does not request review of an initial full or partial denial; or

- The refund must be made to the beneficiary within 15 days after the date the physician/supplier receives the notice of the review determination if the physician/supplier requests review within 30 days of receipt of the notice of the initial determination.

Physicians/suppliers who knowingly and willfully fail to make a refund where required within these time limits may be subject to civil money penalties and/or exclusion from the Medicare program.

The beneficiary should contact the contractor or CMS when a physician/supplier fails to make a timely refund. If the contractor determines that a physician/supplier failed to make a refund, it will contact the physician/supplier in person or by telephone to discuss the facts of the case. The contractor will attempt to determine why the required refund has not been made and will explain the legal requirements. The contractor will determine whether referral to the Office of Inspector General (OIG) or CMS is appropriate and will make appropriate referrals OIG if necessary. The OIG or CMS may impose civil money penalties, assessments, and sanctions if he or she fails to make the required refund. The contractor will retain a detailed written report of contact.

50.13.4 - Supplier's Right to Recover Resalable Items for Which Refund Has Been Made (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

If the Medicare contractor denies Part B payment for an item of medical equipment or supplies on the

basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, and the beneficiary is relieved of liability for payment for that item under §1834(a)(18) of the Act, the effect of the denial, subject to State law, cancels the contract for the sale or rental of the item. If the item is resalable or re-rentable, the supplier is permitted to repossess the item. Suppliers are strongly discouraged from recovering items which are consumable or not fit for resale or re-rental.

If a supplier makes proper refund under §1834(a)(18) of the Act, Medicare rules do not prohibit the supplier from recovering from the beneficiary items which are resalable or re-rentable. When the contract of sale or rental is cancelled on the basis described above, the supplier may enter into a new sale or rental transaction with the beneficiary as long as the beneficiary has been informed of their liability. If the circumstances which preclude payment for the item have been removed (e.g. the supplier has now obtained a supplier number when that supplier did not have one before), the supplier may submit to the Medicare contractor a new claim based on the resale or re-rental of the item to the beneficiary. If payment is still precluded, the supplier can issue an ABN. Under the capped-rental method, if the Medicare contractor determines that the supplier is obligated to make a refund, the supplier must repay Medicare those rental payments that the supplier has received for the item. However, the Medicare beneficiary must return the item to the supplier.

50.14 - CMS Regional Office (RO) Referral Procedures (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Prior to submitting any materials to the RO, the Medicare contractor will contact the RO to determine how to proceed in referring a potential sanction case for violation of refund requirements. When referring these types of cases to the region, the contractor should include the following:

A. Background of the Subject

The subject's business name, address, Medicare Identification Number, owner's full name and Social Security Number, Tax Identification Number (if different), and a brief description of the subject's special field of medical equipment, supplies, or services.

B. Origin of the Case

A brief description of how the violations were discovered.

C. Statement of Facts

A statement of facts in chronological order describing each failure to comply with the refund requirements.

D. Documentation

Include copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiary and the supplier regarding the supplier's failure to make a refund. Include a listing of the following for each item or service not refunded to the beneficiary by the supplier (grouped by beneficiary):

- Beneficiary Name and Health Insurance Claim Number;
- Claim Control Number;
- Procedure Code (CPT-4 or HCPCS) of nonrefunded item or service;
- Procedure Code modifier;
- Date of Service;
- Place of Service Code;
- Submitted Charge;
- Units (quantity) of Item or Service; and
- Amount Requested to be Refunded.

Include any additional information that may be of value to the RO.

50.15 - Special Considerations
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

50.15.1 - Obligation to Bill Medicare
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Upon receipt of an ABN, beneficiaries always have the right to ask the notifer to submit a claim to Medicare for an official payment decision. A beneficiary must receive the item/service described in the ABN and choose Option 1 in order to request Medicare claim submission.

Providers/suppliers should refer to Publication 100-4, Chapter 1, Section 60 for instructions on submitting claims for statutorily noncovered items or services.

Note: Providers/suppliers will not violate mandatory claims submission rules under Section1848 of the Social Security Act when a claim is not submitted to Medicare at the beneficiary's request by their choice of Option 2 on the ABN.

50.15.2 - Emergencies or Urgent Situations/ Ambulance Transport
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. ABN issuance in emergency or urgent situations -

In general, a notifier may not issue an ABN to a beneficiary who has a medical emergency or is

under similar duress. Forcing delivery of an ABN during an emergency may be considered coercive. ABN usage in the ER may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.

B. ABN issuance for ambulance transport -

Issuance of the ABN is mandatory for ambulance transport services if all of the following 3 criteria are met:

1. The service being provided is a Medicare covered ambulance benefit under §1861(s)(7) of the SSA and regulations under this section as stipulated in 42 CFR §410.40 -.41;

2. The provider believes that the service may be denied, in part or in full, as "not reasonable and necessary" under § 1862(a)(1)(A) for the beneficiary on that particular occasion; and

3. The ambulance service is being provided in a non-emergency situation. (The patient is not under duress.)

Simplified, there are three questions to ask when determining if an ABN is required for an ambulance transport. If the answer to **all** of the following 3 questions is "yes", an ABN must be issued:

1. Is this service a covered ambulance benefit? AND

2. Will payment for part or all of this service be denied because it is not reasonable and necessary? AND

3. Is the patient stable and the transport non-emergent?

Example: A beneficiary requires ambulance transportation from her SNF to dialysis but insists on being transported to a new dialysis center 10 miles beyond the nearest dialysis facility.

Medicare covers this type of transport; however, since this particular transport is not to the nearest facility, it is not considered a covered Medicare benefit. Therefore, NO ABN is required. As a courtesy to the beneficiary, an ABN could be issued as a voluntary notice alerting her to the financial responsibility.

Example: A beneficiary requires non-emergent ground transport from a local hospital to the nearest tertiary hospital facility; however, his family wants him taken by air ambulance.

The ambulance service is a covered benefit, but the level of service (air transport) is not reasonable and necessary for this patient's condition. Therefore, an ABN MUST be issued prior to providing the

service in order for the provider to shift liability to the beneficiary.

ABN issuance is mandatory only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. If an ambulance transport is statutorily excluded from coverage because it fails to meet Medicare's definition of the ambulance benefit, a voluntary ABN may be issued to notify the beneficiary of his/her financial liability as a courtesy.

50.15.3 - Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

50.15.3.1 - Special Issues Associated with the ABN for Hospice Providers (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. General Use - Hospice

Hospice providers issue the ABN, Form CMS-R-131, according to the instructions given in this section. Mandatory use of the ABN is very limited for hospices. Hospice providers are responsible for providing the ABN when required as listed below for items

and services billable to hospice. Hospices are not responsible for issuing an ABN when a hospice patient seeks care outside of the hospice's jurisdiction.

The three situations that would require issuance of the ABN by a hospice are:

- Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in §1879(g)(2) of the Act;

- Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either §1862(a)(1)(A) or §1862(a)(1)(C); or

- The level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

Below are examples of scenarios that mandate ABN issuance and the accompanying denial reason that could be listed in Blank (E) on the ABN.

Example A:

Patient with chronic obstructive pulmonary disease and congestive heart failure is referred for hospice care; however, the hospice physician determines that the severity of the patient's diseases

has recently improved with medical management, and the patient is not terminal.

Reason in Blank "E" on the ABN: "Medicare does not pay for hospice care when your illness is not considered terminal."

Example B:

A hospice patient's care was upgraded from Routine Home Care (RHC) to Continuous Home Care (CHC) during a period of crisis. The medical crisis improved and resolved so that CHC was no longer medically reasonable and necessary. The family requested that CHC services be provided for two more days and were willing to pay out of pocket for the additional care. (The family did not want respite care services.)

Reason in Blank "E" on the ABN: "Medicare will not pay for this level of care when it is not medically reasonable and necessary."

Example C:

A hospice patient's family requests daily physician visits that are not medically reasonable and necessary for the patient's current condition.

Reason in Blank "E" on the ABN: "Medicare will not pay for physician visits that are not medically reasonable and necessary."

End of all Medicare covered hospice care –

When it is determined that a beneficiary who has been receiving hospice care is no longer terminally ill and the patient is going to be discharged from hospice, the hospice may be required to issue the Notice of Medicare Noncoverage (NOMNC), CMS 10123 (see the "FFS ED Notices" link on the CMS website at http://www.cms.gov/Medicare/Medicare- General-Information/BNI/index.html for details). If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the noncovered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.

B. Hospice Care Delivered by Non-Hospice Providers

It is the hospice's responsibility to issue an ABN when a beneficiary who has elected the hospice benefit chooses to receive inpatient hospice care in a hospital that is not under contract with the hospice. The hospice may delegate delivery of the ABN to the hospital in these cases.

C. When ABNs Are Not Required for Hospice Services

1. Revocations

Hospice beneficiaries or their representatives can revoke the hospice benefit. Revocations are not considered terminations under liability notice policy since the beneficiary is exercising his/her own freedom of choice. Therefore, no ABN is required.

2. Respite Care Beyond Five Consecutive Days

Respite care is limited to five consecutive days under the Act. When respite care exceeds five consecutive days, an ABN is not required since additional days of respite care are not part of the hospice benefit. CMS encourages hospice providers to give the ABN as a voluntary notice to inform patients of financial liability when more than five days of respite care will be provided.

3. Transfers

Beneficiaries are allowed one transfer to another hospice during a benefit period. However, subsequent transfers within the same benefit period are not permitted. In either case, an ABN is not required.

4. Failure to Meet the Face to Face Requirement

The ABN must not be issued when the face to face requirement for hospice recertification is not met within the required timeframe. Failure to meet the face to face requirement for recertification should not be misrepresented as a determination that the beneficiary is no longer terminally ill.

5. Room and Board Costs for Nursing Facility Residents

Since room and board are not part of the hospice benefit, an ABN would not be required when the patient elects hospice and continues to pay out of pocket for long term care room and board.

50.15.3.2 - Special Issues Associated with the ABN for CORFs (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Since Comprehensive Outpatient Rehabilitation Facility (CORF) services are billed under Part B, CORF providers must issue the ABN according to the instructions given in this section. The ABN is issued by CORFs before providing a service that is usually covered by Medicare but may not be paid for in a specific case because it is not medically reasonable and necessary.

When all Medicare covered CORF services are going to end, CORF's are required to issue a notice regarding the beneficiary's right to an expedited determination called a Notice of Medicare Noncoverage (NOMNC), CMS 10123. Please see the "FFS ED Notices" link on the CMS website at http://www.cms.gov/Medicare/Medicare-General- Information/BNI/index.html for these notification requirements. Upon termination of all CORF care, the ABN would be issued only if the beneficiary

wants to continue receiving some or all services that will not be covered by Medicare because they are no longer considered medically reasonable and necessary. An ABN would not be issued if no further CORF services are provided.

50.15.4 - Home Health Agency use of the ABN
(Rev. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14)

A. General Use - HHAs

The ABN replaces the Home Health Advance Beneficiary Notice (HHABN), Form CMS- R-296, Option Box 1. Background information on the HHABN and information pertaining to the Home Health Change of Care Notice (HHCCN), Form CMS-10280, which replaces the HHABN Option Box 2 and 3 formats, can be found in Section 60 of this chapter. Do not use the ABN in place of HHABN Option Box 2 or HHABN Option Box 3.

HHAs are required to issue an ABN to Original Medicare beneficiaries in specific situations where "limitation on liability" (LOL) protection is afforded under §1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1 below). In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, HHAs may use the ABN to shift liability for the non-covered home care to the beneficiary.

ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL protections.

HHAs should contact their A/B MAC (HHH) if they have questions on the ABN or related instructions, since A/B MACs (HHH) process home health claims for Original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes:

Table 1.
Application of LOL for the Home Health Benefit

Citation from the Act	Brief Description of Situation	Recommended Explanation for "Reason Medicare May Not Pay" section of ABN
§1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for care that is not medically reasonable and necessary.
§1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for custodial care, except for some hospice services.

§1879(g)(1)(A)	Beneficiary is not homebound	Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit
§1879(g)(1)(B)	Beneficiary does not need skilled nursing care on an intermittent basis	Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit

A. Home Health Care Triggering Events

HHAs may be required to provide an ABN to an Original Medicare beneficiary when a triggering event occurs. Section 50.5 explains triggering events in general, and they are outlined specific to home health care below.

Table 2 - Triggering Events for ABN issuance by HHAs*

Event	Description
Initiation	When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.
Reduction	When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.
Termination	When an HHA expects that Medicare coverage will end for all items and services in total.

*ABN issuance is only required when the HHA is going to provide the beneficiary with the item or service that is being initiated, reduced, or terminated as described in the Table

2. If the beneficiary does not want the item or service that is being initiated, reduced, or terminated, no ABN is required.

HHA Initiations

Initiations occur at the start of home health care and may also occur when a service is added to an existing home health plan of care (POC). An ABN must be issued to the beneficiary prior to receiving care that is usually covered by Medicare, but in this particular instance, it is not covered or may not be covered by Medicare because:

- the care is not medically reasonable and necessary,
- the beneficiary is not confined to his/her home (considered homebound),
- the beneficiary does not need skilled nursing care on an intermittent basis, or
- the beneficiary is receiving custodial care only.

If the HHA believes that Medicare will not or may not pay for care for a reason other than one listed directly above, issuance of the ABN is not required.

An ABN is required at initiation only when there is potential for the beneficiary or his/her secondary insurance to incur a charge. The ABN informs the beneficiary of the potential charges and allows him/her to make a decision regarding whether or not s/he wants care that won't be paid for by Medicare. An ABN signed at initiation of home health care for items and/or services not covered by Medicare is effective for up to a year, as long as the items/services being given remain unchanged from those listed on the notice.

Example 1 – Initiation:

A beneficiary requires skilled nursing wound care 3 times weekly; however, she is not confined to the home. She wants the care done at her home by the HHA.

The ABN must be issued to this beneficiary before providing home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether or not to receive the non-covered care and accept the financial obligation.

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events and is subject to ABN issuance requirements if applicable. When an HHA performs an initial assessment of a beneficiary prior to admission but does not admit the beneficiary, an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, the HHA must provide notice to the beneficiary before performing and charging for this service.

Since Medicare has specific requirements for payment of home health services, there may be occasions where a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the ABN to transfer liability to the beneficiary when there is concern that a billing requirement may not be met. (For example, a home health agency can't issue an ABN at initiation of home care services in order to charge the beneficiary if the provider face to face encounter requirement is not met.)

Reductions

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care, provided by the HHA and/or care that is part of the POC. If a reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assume the financial charges, the HHA must issue the ABN prior to providing the noncovered items or services. Technically, this is an initiation of noncovered services following a reduction of services.

Example 2 - Reduction with subsequent initiation:

The beneficiary requires physical therapy (PT) for gait retraining 5 times per week for 2 weeks, then reduce to 3 times weekly for 2 weeks. After 2 weeks of PT, the beneficiary wants to continue therapy 5 times a week even though this amount of therapy is no longer medically reasonable and necessary. The HHA would issue an ABN to the beneficiary so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

3. Terminations

A termination is the cessation of all Medicare covered services provided by the HHA. If the patient wants to continue receiving care from the HHA that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services, an ABN must be issued to the beneficiary in order for the HHA to charge the beneficiary or secondary insurer. If the beneficiary won't be getting any further home care after discharge, there is no need for ABN issuance. When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS- 10123. The NOMNC informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on the CMS website under the link for "FFS ED Notices" at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued to the beneficiary since this would be an initiation of non-covered care.

B. Effect of Other Insurers/Payers

If a beneficiary is eligible for both Original Medicare and Medicaid (dually eligible) or is covered by Original Medicare and another insurance program or payer, ABN requirements still apply. Other payers can include waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants. When issuing ABNs to dual eligibles, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by the other payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary. When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option 1 on the ABN. HHAs may add a statement in the "Additional Information" section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care with your other insurance," or "Your Medical Assistance plan will pay for this care." HHAs may also use the "Additional Information" on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the "Additional Information" section of the notice.

Some States have specific rules established regarding HHA completion of liability notices

in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort", meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. **Note: If there has been a State directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.**

HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the State's Medicaid directive. If the HHA's State Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2. When Option 2 is chosen based on State guidance, but the HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the "Additional Information" box such as "Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan."

C. HHA Exceptions to ABN Notification Requirements

ABN issuance is NOT required in the following HHA situations:

- initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;
- care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance);
- telehealth monitoring used as an adjunct to regular covered HH care; or
- noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH prospective payment system (PPS) episode payment).

D. ABN for Voluntary Notice by HHAs

HHAs may also use the ABN as a voluntary notice as described in Section 50.3.2.

Example 3 - Voluntary ABN issuance by an HHA:

A beneficiary is receiving home health services, and his physician orders telehealth monitoring as an adjunct to the regular home health visits. The HHA elects to issue the ABN before telehealth monitoring begins as a courtesy to the beneficiary and to prepare him for future billing statements. Per §1895(e) of the SSA, telehealth services are outside of the scope of HHA services covered by the prospective payment system. Thus, HHAs providing telehealth as an addition to covered Medicare services are not required to issue an ABN for the never covered telehealth services.

E. Effect of Initial Payment Determinations on Liability

An ABN informs a beneficiary of his/her HHA's expectation with regard to Medicare coverage. If the care described on the ABN is provided, Medicare makes an actual payment determination on the items and/or services at issue when adjudicating the related claim. Such adjudications may uphold the provider's expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid ABN. However, adjudication may not conform to the provider's expectation, in which case the decision made on the claim supersedes the expectation given on the ABN. That is, Medicare may cover and pay for care despite the HHA's expectation, or deny the claims and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must promptly refund the appropriate amount to the beneficiary.

F. Use of abbreviations

HHAs were instructed to avoid using abbreviations when using the HHABN. When completing the ABN, HHAs must avoid using abbreviations in the body of the notice unless the abbreviation is already spelled out elsewhere. For example, an abbreviation such as "PT" that can have multiple meanings in a home health setting (part-time, physical therapy, prothrombin time) should be spelled out at least once on the ABN next to the abbreviation of the word(s). When this is done, the abbreviation can be used again on the notice. ABNs containing abbreviations that are not defined in this manner on the notice may be invalidated by contractors.

G. Cost Estimate

HHAs should follow the ABN form instruction guidelines for providing cost estimates for items or services. The cost estimate must be a good faith estimate based on agency charges and the expected frequency and duration of each service. Cost estimates per visit or per number of visits weekly are acceptable. A difference in the cost estimate and actual cost will not automatically invalidate the ABN. The cost estimate must give the beneficiary an idea of what his/her out of pocket costs might be if s/he chooses to receive

the care listed on the ABN.

Cost estimate examples:

$440 for 4 weekly nursing visits in 1/13.
$260 for 3 physical therapy visits 1/3-1/7/13.
$50 for spare right arm splint.

When more than one item and/or service is at issue, the HHA must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate.

50.15.5 - Outpatient Therapy Services
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. American Taxpayer Relief Act (ATRA) of 2012 (PL 112-240, January 3, 2013) and Outpatient Therapy Services

Section 603 (c) of the ATRA amended §1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn't required for the beneficiary to be held financially liable. **Now, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable.** ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

B. Mandatory ABN issuance for therapy services

Therapists are required to issue the ABN to beneficiaries prior to providing therapy that is not medically reasonable and necessary regardless of the therapy cap. Statutory changes (described in the section above) mandate ABN issuance when therapy services that aren't medically reasonable and necessary exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that won't be covered by Medicare because the services aren't

medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether or not to get the services and accept financial responsibility for them.

Example 1 – Therapy cap is not met - ABN Mandatory

Mr. X has been receiving physical therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the plan of care (POC). The total amount applied to his therapy cap this year is $780. Mr. X requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that won't be covered by Medicare because they are no longer medically necessary.

Example 2 – Therapy cap has been met - ABN Mandatory

Ms. Z has recently been receiving physical therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. Ms. Z. requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

Sample wording for ABN completion in either Example 1 or 2:

1st column of ABN table labeled "D". (Remove "D" and all other lettering on the ABN prior to issuance and insert "Services" in all blanks labeled "D".)

"Physical therapy services two times per week for three weeks."

Under column labeled "Reason Medicare May Not Pay":

"You have met your physical therapy goals, and physical therapy is no longer medically necessary. Medicare doesn't pay for physical therapy services that aren't medically reasonable and necessary."

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

Example 3 – Therapy cap met - No ABN required

Mr. A has been receiving PT three times a week and has not met his PT goals. Mr. A has

met his therapy cap of $1900, but additional PT above the cap is medically reasonable and necessary. Since Mr. A qualifies for a therapy cap exception, his continued therapy above the cap will be covered by Medicare. When the therapist submits claims for the necessary therapy that exceeds the cap amount, the –KX modifier is used to attest that therapy beyond the cap amount is medically reasonable and necessary. In this example, an ABN is not issued to Mr. A. since the ABN is only issued for therapy above the cap that is not medically reasonable and necessary.

Providers/suppliers must not issue the ABN to all beneficiaries who receive services that exceed the cap amount.

C. Voluntary ABN issuance for therapy services

With the aforementioned ATRA changes to liability protections for therapy services, a provider/supplier will seldom encounter situations for using a voluntary ABN or an optional notification for non-covered therapy services. (See 50.3.2 for information on voluntary ABN issuance.)

An example of therapy services that are never covered by Medicare are physical therapy services rendered by a chiropractor. So, a chiropractor offering physical therapy services as allowed by his/her state's scope of practice could issue a voluntary ABN to the beneficiary.

D. ABN issuance for services above the therapy threshold

Therapy threshold amounts are greater than therapy cap amounts. Since the ATRA amendment of §1833(g)(5) of the Act provides limitation of liability protections for therapy services above the cap, therapy services above the threshold are affected. Prior to this statutory amendment, providers weren't required to issue an ABN when providing services in excess of the threshold, and if Medicare denied a claim for services above the threshold, the beneficiary could be held financially liable. Now, ABN issuance is required in order to transfer liability to the beneficiary for therapy services above the threshold that are not medically reasonable and necessary. In some cases, an ABN issued for therapy services above the cap will be effective for therapy above the threshold.
When the beneficiary nears the annual threshold, a step-wise approach can help determine if ABN issuance is required.

Step 1: Was an ABN already issued for therapy above the cap?

a. Yes – ABN issued, services above the threshold listed

If the beneficiary has already received an ABN for therapy above the cap listing the therapy services to be provided in excess of the threshold, the ABN requirement has

been met. No additional beneficiary notification is needed.

b. Yes – ABN issued, services above the threshold not listed

If the beneficiary has already received an ABN for therapy above the cap and the ABN doesn't include the therapy services to be provided in excess of the threshold, the provider must issue a new ABN listing the services that won't be covered.

Example: Mr. Jones requires both PT and SLP services. He reached the cap amount for PT-SLP services, and PT goals were met. However, Mr. Jones requested continued PT services that were not medically necessary; so, an ABN for continued PT services was issued per CMS guidelines. Mr. Jones had not met SLP goals when he reached the cap amount for PT-SLP services. SLP services above the cap were medically reasonable and necessary and covered by the Medicare therapy exceptions process. He met SLP goals just as he reached the threshold for PT-SLP services. He has requested continued SLP services that aren't medically necessary. A separate ABN for the SLP services must be issued.

c. No – ABN never issued.

An ABN was never issued for therapy services because the beneficiary received therapy above the cap amount that was medically reasonable and necessary and covered as a Medicare therapy exception.

Go to Step 2.

Step 2: Are therapy services above the threshold medically reasonable and necessary?

a. Yes

When the provider believes that therapy services above the threshold are medically reasonable and necessary, an ABN should not be issued. Go to Step 3.

b. No

At any point, when the provider believes that therapy services won't be covered by Medicare because they aren't medically reasonable and necessary, an ABN must be issued.

60 - Home Health Change of Care Notice (HHCCN), Form CMS-10280 (Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

This section provides the standards for use by home health agencies (HHAs) in implementing the Home Health Change of Care Notice (HHCCN), Form CMS-10280, requirements. The HHCCN is issued to Original Medicare beneficiaries before reducing or terminating most ongoing care provided by the HHA.

HHCCN Quick Glance Guide This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 60.			
Notice Name	Home Health Change of Care Notice (HHCCN)		
Notice Number	Form CMS-10280		
Issued by	Home Health Agency (HHA) provider		
Recipient	Original Medicare (fee for service) beneficiary receiving home health care		
Pertinent Information	The HHCN replaces HHABN Option Box 2 and Option Box 3. The Advance Beneficiary Notice of Noncoverage (ABN), CMS-R-131, replaces HHABN Option Box 1. See section 50 for ABN information and instructions.		
Change of care notice	Prior to the HHA reducing or discontinuing care listed in the beneficiary's plan of care (POC) for administrative reasons specific to the HHA on that occasion	Immediately on determination, or if possible, provide enough time for the beneficiary to arrange to obtain the reduced or discontinued home health care service(s) from a different HHA.	No.
	Prior to the HHA reducing or discontinuing Medicare covered care listed in the POC because of a physician ordered change in the plan of care or a lack of orders to continue the care	Notify the beneficiary before the actual reduction or discontinuation, if possible.	No.

The HHCCN replaces the Home Health Advance Beneficiary Notice (HHABN), CMS-R- 296, Option Box 2 and Option Box 3. Option Box 1 of the HHABN is replaced by the existing Advance Beneficiary Notice of Noncoverage (ABN),CMS-R-131, which is detailed in Section 50 of this chapter. HHAs should begin using the ABN and HHCCN in place of the HHABN as soon as possible since the HHABN will be discontinued. The date for mandatory use of the HHCCN and ABN in place of the HHABN will be posted on the web link for home health notices at http://www.cms.gov/Medicare/Medicare- General-Information/BNI/index.html.

Table 1 HHA Notice Changes

Instead of:	Use:
HHABN Option Box 1	ABN (CMS-R-131)
HHABN Option Box 2	HHCCN
HHABN Option Box 3	HHCCN

60.1 - Background on the HHCCN
(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

HHAs have issued HHABNs related to the absence or cessation of Medicare coverage when a beneficiary had liability protection under §1879 of the Social Security Act (the Act) since 2002. The HHABN gained additional notification capabilities in 2006 following the U.S. Court of Appeals (2nd Circuit) decision in Lutwin v. Thompson, 361 F.3d 146; 2004 U.S. App. LEXIS 3774. Following Lutwin, the HHABN was modified so that it could also be used by HHAs to notify beneficiaries receiving home health services of any care changes in accordance with the HHA conditions of participation (COPs) in §1891 of the Act.

To account for this expanded use, the HHABN was revised to contain three interchangeable Option Boxes within the body of the notice designated as Option Box 1, Option Box 2, and Option Box 3. Option Box 1 language was applicable to situations involving potential beneficiary liability for HHA services as directed by §1879 of the Act. Option Box 2 or Option Box 3 was inserted into the HHABN form to notify beneficiaries of changes in a home health plan of care that are subject to the requirements of § 1891 of the Act.

In order to streamline, reduce, and simplify notices issued to Medicare beneficiaries, the HHABN is being discontinued. HHABN, Option Box 1, which is the liability portion of the notice, is replaced by the existing Advance Beneficiary Notice of Noncoverage (ABN), CMS-R-131. The change of care notification portions of the HHABN, Option Box 2 and Option Box 3, is replaced by the newly approved HHCCN.

60.2 - Scope of the HHCCN
(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Statutory Authorization for HHCCN

The requirement to give an HHCCN is based on the HHA COPs in §1891 of the Act. The COPs are further implemented through Title 42 of the Code of Federal Regulations (CFR), Part 484.

§1891(a)(1)(E) stipulates that beneficiaries have:

"The right to be fully informed orally and in writing (in advance of coming under the care of the [home health] agency) of –

all items and services furnished by (or under arrangement with) the agency for which payment may be made under this title,

the coverage available for such items and services under this title, title XIX or any other Federal program of which the agency is reasonably aware, any charges for items and services not covered under this title and any charges the individual may have to pay with respect to items and services furnished by (or under arrangement with) the agency, and

any changes in the charges or items and services described in clause (i), (ii) or (iii)."

HHAs are required to use the HHCCN to notify the beneficiary of reductions and terminations in health care in accordance with Medicare COPs.

B. HHAs and Other CMS Notices

HHAs will now use the Advanced Beneficiary Notice (ABN), Form CMS-R-131 for liability notification instead of the HHABN Option Box 1. The ABN and form instructions can be downloaded from the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

HHAs must continue to issue an expedited determination notice called the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123, if applicable, when all covered services are being terminated. Please see the "FFS ED Notices" link at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html for information on the delivery of expedited determination notices.

C. HHCCN Issuers and Recipients

HHAs are the only type of Medicare provider that issues the HHCCN to notify the beneficiary of care changes involving reductions or terminations of items and/or services. The recipients of the HHCCN are beneficiaries enrolled in Original Medicare only. HHCCNs are not used in Medicare managed care. When a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, HHCCN issuance is required only if there is a specific need to provide notification of changes in care as the transfer occurs.

Subcontractors may deliver HHCCNs under the direction of a primary HHA; however,

notification responsibility, including effective delivery, always rests with the primary HHA. HHAs are always responsible for providing HHCCNs associated with the care that they provide. In the form instructions and instructions in this section, the term “beneficiary” is used to mean the beneficiary or the beneficiary's representative, as applicable. For more information on representatives, see §40.3.5 and §40.3.4.3 of this chapter.

HHAs should contact their CMS Regional Office if they have questions on the HHCCN or related instructions. Beneficiaries who need assistance may be directed to call 1-800-MEDICARE.

60.3 - Triggering Events for HHCCN/Written Notice (Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

HHAs may be required to provide an HHCCN to an Original Medicare beneficiary at two points in time, for reasons not related to Medicare coverage called “triggering events”:

Table 2
Triggering Events for HHCCN Issuance

Event	Description
Reduction of a service	When an HHA reduces or stops an item and/or service during a spell of illness while continuing others, including when one home health discipline ends but others continue.
Termination of all services	When an HHA ends delivery of all services.

A. Reductions

Reductions involve any decrease in items and/or services, such as frequency, amount, or level of care, provided by the HHA. When care that is listed on the POC or provided by the HHA is reduced, the beneficiary must receive the HHCCN listing the items/services being reduced and the reason for the reduction, regardless of who is responsible for paying for that service.

When a reduction occurs because the HHA decides to stop providing the service for administrative reasons or because of a physician’s order, the HHCCN must be issued.

Example 1 – Reduction for HHA reasons:

Because of a temporary staffing shortage, an HHA reduces daily physical therapy (PT) to PT 3 times weekly for 2 weeks.

The HHCCN must be issued to the beneficiary prior to this care reduction that is due to

an agency administration issue.

Example 2 –Reduction based on physician's orders:

The beneficiary met PT goals sooner than expected, and the attending physician writes an order to discontinue home PT. Physical therapy services are discontinued with no change in existing skilled nursing orders.

The HHCCN must be issued to the beneficiary prior to this care reduction that is a change to the existing POC because of a physician's order. Reductions include cases, such as this, where one type of care ends, but the beneficiary continues to receive another type of home health service.

An ABN is issued (and not the HHCCN) if a reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assume the financial charges. See Section 50.15.4.

B. Terminations

A termination is the cessation of all services provided by the HHA and can include Medicare covered and noncovered care. When all home health care is ending for reasons not related to Medicare coverage, the HHA issues the HHCCN with information appropriate to the specific situation.

Example 1 – care termination due to agency reasons (such as staffing, closure of the HHA, concerns for staff safety), not related to Medicare coverage.

An HHA decides to stop providing care because guard dogs at the home where the care is being furnished have posed safety issues for staff.

Because termination is due to an HHA administrative decision, the HHCCN must be given to the beneficiary prior to discontinuation of services.

Example 2 – care termination due to agency reasons (failure to meet face to face encounter requirement)

An HHA has initiated care for a beneficiary, and the beneficiary has not yet had the required face to face encounter with the certifying physician or an allowed non-physician practitioner (NPP). The HHA believes that the face to face encounter requirement will not be met in the allowed time frame and decides to stop providing care.

This termination is due to an HHA administrative decision; thus, the HHCCN must be given

to the beneficiary prior to discontinuation of services. Issuing the HHCCN does not affect financial liability but serves as a written change of care notice as required by the HHA COPs.

Example 3 – care termination due to a physician's orders to discontinue care or a lack of orders to continue care

A physician orders discontinuation of all home health services or fails to order continued home health services.

The Notice of Medicare Provider Non-Coverage (NOMNC), CMS-10123 must be issued to the beneficiary when all Medicare covered services are ending based on the physician's orders. Since the NOMNC provides written notification of the forthcoming termination of all home health care, it satisfies the regulatory requirement for change of care advisement (HHCCN issuance). Thus, when the NOMNC is issued as required, the HHA doesn't have to issue a separate HHCCN. When home health services end because of physician's orders, HHAs have the option of issuing the NOMNC alone or both the NOMNC and the HHCCN. Detailed information and instructions for issuing the NOMNC can be found on the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html

C. Effect of Other Insurers/Payers

HHCCN requirements apply only when home health services are expected to be partially or fully covered by Medicare. When a beneficiary is not receiving any services that are expected to be covered under the Medicare home health benefit, the HHCCN is not required. For example, if a dual eligible beneficiary (having both Medicare and Medicaid) is not receiving any Medicare covered home health services, HHCCN issuance wouldn't be required when changes of care occur. (Note: HHAs are required to issue the ABN to dual eligible beneficiaries when applicable. See Section 50.15.4 C)

D. Exceptions to HHCCN Notification Requirements

The HHCCN is NOT required when changes in care involve:

- increase in care;
- changes in HHA caregivers or personnel as decided by the HHA;
- changes in expected arrival or departure time for HHA staff as determined by the HHA;

- changes in brand of product, (i.e., the same item produced by a different manufacturer) as determined by the HHA;

- change in the duration of services that has been included in the POC and communicated to the beneficiary by the HHA, (i.e., shorter therapy sessions as health status improves, such as a reduction from an hour to 45 minutes);

- lessening the number of items or services in cases where a range of services is included in the POC;

Example: The POC order states: PT 3-5x per week as needed for gait training. The therapist begins therapy at 5 times per week, and as the patient progresses, therapy is reduced to 3 times per week. No HHCCN would be needed in this case.

- changes in the mix of services delivered in a specific discipline (e.g., skilled nursing) with no decrease in frequency with which that discipline is delivered;

Example: A beneficiary is receiving several skilled nursing services during visits that are scheduled 3 times a week. One service within that discipline, a blood draw 1 time a week, is discontinued. Other skilled nursing services (wound care and education) continue, such that skilled nursing visits continue to occur 3 times per week. No HHCCN is required when the blood draws are discontinued, only when skilled nursing is reduced in frequency.

- changes in the modality affecting supplies employed as part of specific treatment (e.g., wound care) with no decrease in the frequency with which those supplies are provided; or

Example: A specific wound care product like Alldress is stopped, and a Hydrogel pad is started. Since this represents a change in the modality (or intervention) and not a reduction, no HHCCN is necessary.

- changes in care that are the beneficiary's decision and are documented in the medical record.

60.4 - Completing the HHCCN
(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Notices and General Notice Requirements

The HHCCN and the general instructions for preparing the HHCCN are available for download at the home health notice link found at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

The notice is available in English and Spanish, and in PDF and Word formats. The HHCCN is the Office of Management and Budget (OMB) approved standard notice for use by Medicare HHAs to inform beneficiaries of changes in the POC when required by the COPs for HHAs. HHAs must use the OMB approved standard notice. HHAs must not add any customizations to the notice beyond what is permitted by the accompanying HHCCN form instructions and the guidelines published in this section.

B. Choosing the Correct Language Version

HHAs should choose the appropriate version of the HHCCN based on the language the beneficiary best understands. When a Spanish-language HHCCN is used, the HHA should make insertions on the notice in Spanish. If this is impossible, the HHA must take additional steps needed to assure beneficiary comprehension and document this on the HHCCN.

If needed, HHAs must provide verbal assistance in other languages to assist beneficiaries in understanding the document. HHAs should document any types of translation assistance used in the "Additional Information" section of the notice.

C. Compliance with Paperwork Reduction Act of 1995

Consistent with the Paperwork Reduction Act of 1995, the valid OMB control number for this information collection appearing on the HHCCN is 0938-1196. The estimated time required to complete this information collection is 4 minutes for a single notice. This includes the time to prepare the notice, review it with the beneficiary, and obtain the beneficiary's signature.

D. Effective Dates

HHCCNs are effective for HHA use per the OMB assigned date given at the bottom of each notice unless CMS instructs HHAs otherwise. The routine approval is for 3-year use. HHAs are expected to exclusively use the effective version of the HHCCN per CMS directives.

60.5 - HHCCN Delivery
(Rev. 2781, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

HHAs must make every effort to ensure beneficiaries understand the entire HHCCN prior to signing it. When delivering HHCCNs, HHAs are required to explain the notice and its content, and answer beneficiary questions to the best of their ability. If abbreviations are used, the HHA should explain their meaning to the beneficiary. If the beneficiary requests additional information while completing the HHCCN, the HHA must respond timely,

accurately, and completely to the information request.

While in-person delivery of the HHCCN is preferable, it is not required consistent with general ABN requirements, see Medicare Claims Processing Manual, Chapter 30, §40.3.4.1.

If a mode other than in person delivery is used, the HHA must adhere to the requirements under the Health Insurance Portability and Accountability Act (HIPAA). Instructions on ABN telephone notice found in §40.3.4.2 of this chapter are also applicable to HHCCNs.

Delivery when change of care is due to agency administrative reasons

The HHA should review the text associated with the box that was checked on the HHCCN by the HHA and verbally explain to the beneficiary that he/she may be able to obtain the same or similar care from another HHA, since coverage through Medicare is not affected. HHAs are encouraged to do as much as possible to offer ideas to beneficiaries for contacting other HHAs and must inform ordering physicians of reductions/terminations consistent with the COPs for HHAs.

Delivery when change of care is due to physician orders

The HHA should review the text associated with the box that was checked on the HHCCN by the HHA, and inform the beneficiary that the HHA will no longer provide certain care because the physician's order has changed. When requested, the HHA may facilitate contact and understanding between the physician and beneficiary. The beneficiary may also seek to contact the physician directly.

Retention of the HHCCN

The HHA keeps a copy of the completed, signed or annotated HHCCN in the beneficiary's record, and the beneficiary receives a copy. HHA's may retain a scanned copy of the paper copy document in an electronic medical record if desired. The primary HHA must retain the HHCCN if a subcontractor is used.

Applicable retention periods are discussed in Chapter 1 of this manual, §110. In general, this is 5 years from discharge when there are no other applicable requirements under State law.

Other Considerations During Completion

1. Beneficiary Unable to Sign

If the beneficiary is physically unable to sign the HHCCN and is fully capable of

understanding the notice a representative is not required for signature. The beneficiary may allow the HHA to annotate the HHCCN on his/her behalf regarding this circumstance. For example, a fully cognizant beneficiary with two broken hands may allow an HHA staff person to sign and date the notice in the presence of and under the direction of the beneficiary, inserting the beneficiary's name along with his/her own name, i.e., "John Smith, Shiny HHA, signing for Jane Doe." Such signatures should be witnessed by a second person whenever possible. Further, the medical record should support the beneficiary's inability to write in the applicable time period.

2. Timely Notice

There are no exact time frames for HHCCN delivery. Delivery timing of the notice may sometimes occur immediately upon the HHA finding that a change in care is warranted. However, in general, HHCCN should be delivered far enough in advance of the care change so that the beneficiary may pursue alternatives to continue receiving the care noted on the HHCCN. When plans for issuance of the notice are known in advance, the HHCCN should not be issued so far in advance as to cause confusion regarding the information it conveys.

Some allowance is made for "immediate" delivery prior to furnishing the care at issue when unforeseen circumstances arise such as an impending, unforeseen agency staffing shortage or a dangerous home situation. This should be avoided whenever possible, but is permissible when a situation occurs prompting an immediate determination to reduce or end services that could not have been made in advance.

70 - Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
(Rev. 1983, Issued: June 11, 2010; Effective/Implementation Dates: July 12, 2010)

The following are the standards for use by Skilled Nursing Facilities (SNFs) in implementing the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, model Form CMS-10055) notice of noncoverage requirements. This section provides instructions, consistent with the skilled nursing facility prospective payment process (SNF PPS), regarding the notice that SNFs must provide to beneficiaries in advance of furnishing what SNFs, utilization review (UR) entities, quality improvement organizations (QIOs), or Medicare contractors believe to be noncovered extended care services, or items or of reducing or terminating ongoing covered extended care services or items.

SNFs may continue using either the SNFABN or the SNF Notices of Noncoverage (Denial Letters) to fulfill the notification requirements under Section 1879 of the Social Security

Act. When completing and delivering the SNFABN, SNFs must meet the notice standards in §70.3 of Chapter 30 of the Medicare Claims Processing Manual.

SNFs must also meet the ABN Standards in §40.3of the Medicare Claims Processing Manual in completing and delivering SNFABNs.

70.1 - Basic Requirements for SNFABNs (Rev. 1, 10-01-03)

A SNFABN is a CMS-approved model written notice that the SNF gives to a Medicare beneficiary, or to her or his authorized representative, before extended care services or items are furnished, reduced, or terminated when the SNF, the UR entity, the QIO, or the Medicare contractor believes that Medicare will not pay for, or will not continue to pay for, extended care services that the SNF furnishes and that a physician ordered on the basis of one of the following statutory exclusions:

- Not reasonable and necessary ("medical necessity") for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member -

§1862(a)(1); or

- Custodial care ("not a covered level of care") - §1862(a)(9).

Except for the exclusions specified above, there is no other statutory authority on which the limitation on liability (LOL, §1879) provision applies to SNF claims denied.

Note: The terminology "Medicare will not pay" is used here and in the SNFABN because it is a concept understandable to beneficiaries. A Medicare official determination in favor of the beneficiary will not necessarily result in additional Medicare payments being made under the SNF PPS.

70.1.1 - Approved Model Form (Rev. 1, 10-01-03)

The SNFABN (viz., CMS-approved model Form CMS-10055) is for use with SNF PPS services. This form satisfies the requirements under LOL for advance beneficiary notice and the beneficiary's agreement to pay. The use of any other notices or of modified SNFABNs may be ineffective in protecting users from liability. The SNFABN must be prepared with an original and at least one patient copy, a SNF copy containing the signature of the patient or authorized representative, an attending physician copy, and (when necessary) a Medicare contractor copy. SNFs may produce SNFABNs using self- carboning paper and other methods of producing copies, including photocopying, printing, and electronic generation,

but they should conform to the Form CMS-10055 design.

70.1.2 - User-Customizable Section (Rev. 1, 10-01-03)

Users (SNFs) are permitted to customize the header and the "Items or Services" and "Because" areas on the Form CMS-10055. The contractor will not invalidate a SNFABN solely on the basis that the SNF included in the header and in the two other customizable areas some item(s) of information (e.g., information about the SNFABN's implications for the beneficiary's other insurers) which is/are not explicitly required by these instructions. The SNFABN is designed as a letter-size form; nevertheless, it may be expanded to a legal size form by a user, to allow increasing the size of the customizable header and the "Items or Services" and "Because" areas, to suit the user's particular needs. In any case, the SNFABN must be only one page in length and should be modified only in the specified user-customizable sections. The standard sections of the SNFABN (those sections which are not specified as user-customizable) should not be modified in any respect from the replicable PDF (abode acrobat) form. The use of improperly modified SNFABNs may be ineffective in protecting users from liability.

70.1.3 - Where to Obtain the SNFABN Form (Rev. 1, 10-01-03)

The replicable copy of the Form CMS-10055 in PDF (Adobe Acrobat) format is available online at the CMS Beneficiary Notices Initiative (BNI) Web page at: http://www.cms.hhs.gov/medicare/bni/ under:

- Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN).

70.2 - When and to Whom a SNFABN Should Be Given (Rev. 1, 10-01-03)

70.2.1 - When and to Whom a SNFABN Should Be Given (Rev. 1, 10-01-03)

Whether a SNFABN should be given in a particular instance depends on the SNF's expectation of Medicare payment or denial for extended care services that it furnishes.

- If the SNF expects Medicare to pay, a SNFABN should not be given.
- If the SNF "never knows whether or not Medicare will pay," a SNFABN should not be given.

- If the SNF expects Medicare to deny payment, the next question is: "On what basis is denial expected?"

70.2.2 - Situations inWhich SNFABN Is Not Given (Rev. 1, 10-01-03)

SNFs are not to give patients SNFABNs in situations where they are not appropriate.

70.2.2.1 - Categorical Exclusions (Rev. 1, 10-01-03)

With the exception of the two qualifying categorical exclusions, viz., the "not reasonable or necessary" ("medical necessity") exclusion under §1862(a)(1) and the "custodial care" exclusion under §1862(a)(9), if the extended care service or item is not a Medicare benefit (e.g., personal comfort items excluded under §1862(a)(6)), a SNFABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

70.2.2.2 - Technical Exclusions (Rev. 1, 10-01-03)

With the exception of such qualifying technical exclusions as are provided under §§1861(i), 1861(s)(2)(D), 1861(w)(1), and 1888(e)(2)(A)(i); viz., an individual being furnished post-hospital extended care services while a resident in a skilled nursing facility, if Medicare is expected to deny payment for an item or service which is a Medicare benefit because it does not meet a technical benefit requirement (e.g., SNF stay not preceded by the required prior three-day hospital stay), a SNFABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

70.2.2.3 - Services Not Under SNF PPS (Rev. 1, 10-01-03)

SNFABNs are for use with Part A covered extended care services provided in the SNF setting. If Medicare is expected to deny payment for Part B covered medical and other health services which the SNF furnishes, either directly or under arrangements with others, to an inpatient of the SNF, where payment for these services cannot be made under Part A (e.g., the beneficiary has exhausted his/her allowed days of inpatient SNF coverage under Part A in his/her current spell of illness or was determined to be receiving a noncovered level of care), a SNFABN should not be given. For Part B services, a CMS- R-131 ABN may be used, if appropriate. (See §50.8.3, "Form CMS-R-131 ABNs.")

70.2.2.4 - When Extended Care Items or Services Will Not Be Furnished (Rev. 1, 10-01-03)

The SNFABN is not to be given in circumstances in which the SNF will not furnish extended care items or services. (This rule is not applicable in the situation where the beneficiary elects to receive extended care items or services but refuses to sign the SNFABN attesting to being personally and fully responsible for payment, in which case, the SNF may then consider not furnishing the specified items or services (see §40.3.4.6).) A SNFABN is evidence of beneficiary knowledge about the likelihood of Medicare denial, for the purpose of determining financial liability for expenses incurred for extended care items or services furnished to a beneficiary and for which Medicare does not pay. Section 70.2.3 specifies that SNFABNs are to be given with respect to extended care items or services furnished to a beneficiary for which denial is expected. For a SNF to give a beneficiary a SNFABN and then refuse to furnish extended care items or services even though the beneficiary elects to receive these items or services by selecting Option 1, is tantamount to the prohibited practice (see §70.4.4.2) of the SNF pre-selecting Option 2 (not to receive items or services) on a SNFABN.

70.2.2.5 - M+C Enrollees and Non-Medicare Patients (Rev. 1, 10-01-03)

The SNFABN is not to be used for Medicare M+C (Part C) enrollees nor for non- Medicare patients because it is to be used solely for individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B).

70.2.3 - Situations in Which SNFABN Should Be Given (Rev. 1, 10-01-03)

If Medicare is expected to deny payment (entirely or in part) on the basis of one of the exclusions listed in §70.1 for extended care items or services that the SNF furnishes to a beneficiary, a SNFABN should be given to the beneficiary.

70.2.3.1 - Triggering Events (Rev. 1, 10-01-03)

SNFs are required to give a SNFABN to Medicare beneficiaries (including dual-eligibles) when the SNF, the UR entity, the QIO, or the Medicare contractor believes that Medicare will not continue to pay for some or all of the extended care items or services a physician has ordered for the beneficiary. Because of the belief that Medicare will not pay for the extended care items or services ordered by the physician, the SNF is either going to deny, reduce, or terminate the items or services to the beneficiary unless the beneficiary agrees to be personally and fully responsible for payment for such items or services. (Note: A SNFABN is not given when the SNF is unwilling to furnish extended care items or services even if the beneficiary is willing to agree to be personally and fully responsible for

payment for such items or services (see §70.2.2.4).) The SNF must give the Medicare beneficiary a SNFABN before reducing or terminating extended care items or services that the beneficiary already is receiving, and that Medicare has been paying for, if the physician's order for such items or services would still continue care, but the SNF, the UR entity, the QIO, or the Medicare contractor expects payment for the extended care items or services will be denied by Medicare. A SNFABN is required when a SNF determines that Medicare is not likely to pay for otherwise covered extended care items or services that a physician has ordered. SNFs must give a SNFABN whenever a triggering event occurs. (A triggering event is defined as one of three changes to services: initiation, reduction, or termination.) The following circumstances constitute the three triggering events for a SNFABN:

A. Initiation of Services

In the situation in which a SNF advises a beneficiary that it will not accept the beneficiary as a Medicare patient because it expects that Medicare will not pay for the extended care items or services that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it furnishes extended care items or services to the beneficiary.

B. Reduction of Services

In the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it reduces items or services to the beneficiary.

C. Termination of Services

In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary, because it expects that Medicare will not continue to pay for the items or services that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it terminates such extended care items or services.

70.2.3.2 - Dual-Eligibles (Rev. 1, 10-01-03)

If the patient is a Medicare-Medicaid dual-eligible and a triggering event occurs, the SNF needs to give the patient (or authorized representative) a SNFABN.

70.2.3.3 - Medicare as Sole Payer

(Rev. 1, 10-01-03)

When the SNF predicts that Medicare will not pay for extended care items or services ordered by the physician and the physician continues the prescription for those items or services, this means the SNF will reduce or terminate extended care items or services to the beneficiary if Medicare were the sole payer for the items or services. On this basis, we characterize such situations as "triggering events," as described in §70.2.3.1. When, in describing "triggering events," we say "a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay" and "a SNF proposes to stop furnishing all extended care items or services to a beneficiary, because it expects that Medicare will not continue to pay," our premise is that Medicare is the sole payer for the items or services, and necessarily so since we are not promulgating instructions for other insurers. It is true that, on a practical basis, physician- prescribed items or services continue without interruption or reduction when a patient changes "payer eligibility" from Medicare to Medicaid. From the Medicare coverage vantage-point, however, there is a reduction or termination when Medicare, which has been paying, stops paying. In other words, there is a triggering event, which underlies the change in "payer eligibility."

70.2.4 - Routine SNFABN Prohibition
(Rev. 1, 10-01-03)

A SNF will not be held to have violated the prohibition on routine SNFABNs solely on the basis of the number of SNFABNs which the user gives to beneficiaries, when those SNFABNs are justified by the SNF having a genuine reason to give a SNFABN. (See §40.3.6, "Routine Notice Prohibition.")

70.2.5 - To Whom a SNFABN Should Be Given
(Rev. 1, 10-01-03)

A SNFABN may be given to a Medicare beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Ultimately, if a situation arises in which a beneficiary simply cannot receive a SNFABN and this notice cannot be given to an authorized representative, the beneficiary is protected by not having received a SNFABN. A SNF's inability to give notice to a beneficiary directly or through an authorized representative does not allow the SNF to shift liability to the beneficiary.

Note: These SNFABNs do not apply to swing-bed determinations.

70.3 - Delivery of SNFABNs
(Rev. 1, 10-01-03)

70.3.1 - Delivery Must Meet Advance Beneficiary Notice Standards

(Rev. 1, 10-01-03)

A SNF (that is, a qualified notifier as defined in §40.3.2) shall notify a beneficiary by means of timely (as defined in §40.3.3) and effective (as defined in §40.3.4) delivery of a proper notice document (as defined in §40.3.1) to a qualified recipient, viz., to the individual beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Delivery of a SNFABN occurs when the beneficiary or authorized representative both has received the notice and can comprehend its contents. All SNFABNs must include an explanation written in lay language of the SNF's, the UR entity's, the QIO's or the Medicare contractor's reason for believing the items or services will be denied payment. SNFABNs must meet the standards for approved model notice language in §40.3, "Advance Beneficiary Notice Standards."

70.3.2 - SNFABN Specific Delivery Issues
(Rev. 1, 10-01-03)

SNFs must provide SNFABNs in every case where a reduction or termination of items or services is to occur, or where items or services are to be denied before being initiated, if there is a physician's order for such care and the SNF, the UR entity, the QIO, or the Medicare contractor expects payment for the extended care items or services to be denied by Medicare. (For situations in which a physician concurs in the reduction, termination, or denial of items or services, see §70.6.6. For situations in which services are statutorily excluded, see §70.2.2). If the SNF, the UR entity, the QIO, or the Medicare contractor expects that Medicare will not pay for the care, the SNF must advise the beneficiary, orally and in writing, before the extended care item or service is initiated or continued that, in the SNF's opinion, the beneficiary will be fully and personally responsible for payment for the specified extended care item or service that it furnishes. The SNF must issue notices each time, and as soon as, the SNF, the UR entity, the QIO, or the Medicare contractor makes the assessment that it believes that Medicare payment will not be made. To be acceptable, a SNFABN (Form CMS-10055) must meet CMS' standards for cultural competency, must clearly identify the particular extended care item or service, must state that the SNF believes Medicare is likely (or certain) to deny payment for the particular item or service, and must give the SNF's, the UR entity's, the QIO's or the Medicare contractor's reason(s) for its belief that Medicare is likely (or certain) to deny payment for the item or service. The SNF makes an original and two copies of the SNFABN (if the contractor requires a copy, one more copy will be made). The SNF gives the original to the beneficiary (or authorized representative); sends the first copy to the beneficiary's attending physician, and keeps the second copy. The Form CMS-10055 SNFABN is an approved model notice. The online Form CMS-10055 SNFABN should be as closely replicated as possible. Failure to provide a proper SNFABN in situations where a physician has ordered the extended care item or service may result in the SNF being held financially liable under the provisions of Limitation on Liability (LOL), where such provisions apply. (See §40.2.) SNFs may also be sanctioned for violating the conditions of participation (viz.,

42 CFR 483.10) regarding resident (beneficiary) rights.

70.3.3 - Timely Delivery (Rev. 1, 10-01-03)

The contractor will reject SNFABNs that are not given timely. The SNF must notify the beneficiary well enough in advance before terminating or reducing extended care items or services. “Well enough in advance” means the beneficiary has time to make other arrangements. If the SNF, the UR entity, the QIO, or the Medicare contractor denies services, the SNF must notify the beneficiary as required in §70.6.9.2. Last moment delivery of a SNFABN will be considered to be untimely, regardless of the SNF’s intentions. Common sense must be applied to this criterion. If a beneficiary alleges she or he did not receive notice timely, the Medicare contractor will investigate the facts. If the SNF has clearly violated the timely delivery rule, the Medicare contractor will hold that the notice was not properly delivered in advance of terminating or reducing extended care items or services and that the beneficiary was not properly notified. The Medicare contractor will ask the SNF to justify any delays in notification.

70.3.4 - Actual Receipt of Notice Required (Rev. 1, 10-01-03)

If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held financially liable where the LOL provisions apply and the SNF may be held financially liable. It is the SNF’s responsibility to ensure that the beneficiary or the authorized representative actually receives a notice that they can comprehend. Failure to provide a comprehensible notice is also a violation of the conditions of participation and may result in enforcement action.

70.3.5 - Understandability and Comprehensibility of Notice (Rev. 1, 10-01-03)

The beneficiary or authorized representative must be able to understand and comprehend the SNFABN for it to be an effective notice. In general, SNFs should not use abbreviations, diagnosis codes, HCPCS, or similar technical or otherwise unfamiliar language when completing an SNFABN’s “Items or Services” and “Because” customizable areas because the beneficiary is likely not to understand them. Of course, abbreviations, codes, etc., accompanying the spelled-out information are not per se confusing and will not invalidate a SNFABN. The SNF is responsible for ensuring that the SNFABN is completed in a manner such that the beneficiary can read and understand it. A SNFABN that the beneficiary cannot understand is defective and will not protect the SNF from financial liability.

70.4 - Form Instructions for the SNFABN (Form CMS-10055) (Rev. 1, 10-01-03)

70.4.1 - General Rules
(Rev. 1, 10-01-03)

The SNFABN (i.e., model Form CMS-10055) is not a replacement for, but is in addition to, the required UR entity notices. The SNFABN protects the SNF from liability in the event the patient, for some reason, does not receive the UR entity notice.

70.4.1.1 - Delivery of SNFABN When Based on Statutory Exclusion
(Rev. 1, 10-01-03)

The SNF is to prepare and deliver to the patient (Medicare beneficiary) or the patient's authorized representative a SNFABN when it, the UR entity, the QIO, or the Medicare contractor expects Medicare probably will not pay for or will not continue to pay for extended care items or services on the basis of one of the statutory exclusions listed in §70.1.

70.4.1.2 - Guidelines for Replicating the SNFABN Form
(Rev. 1, 10-01-03)

Use of the SNFABN is for model language purposes only and should be replicated as closely as possible. The SNF must ensure that the readability of the SNFABN facilitates beneficiary or authorized representative understanding. No insertions into the blank lines and the two customizable sections of the SNFABN, if typed or printed, should be in italics or be in any font that is difficult to read. If insertions are handwritten, they must be legible. An Arial or Arial Narrow font, or a similarly readable font, in the font size range of 10 point to 12 point, is recommended. Black or dark blue ink on a white background is strongly recommended. A visually high-contrast combination of dark ink on a pale background is required. Low-contrast combinations and block shading are prohibited. In all cases, both the originals and copies of the SNFABN must be legible and of high-contrast. The form must be clear and obvious to the beneficiary that the SNFABN is issued by the SNF rather than by the Medicare program. The Medicare contractor will reject any SNFABN that does not meet these standards.

70.4.1.3 - Modification of the SNFABN Form
(Rev. 1, 10-01-03)

A SNFABN may not be modified except for the header and the two customizable areas; i.e., the "Items or Services" and "Because" sections of the model Form CMS-10055.

70.4.2 - Header of SNFABN
(Rev. 1, 10-01-03)

70.4.2.1 - Customization of CMS-10055 SNFABN Header (Rev. 1, 10-01-03)

The header of the SNFABN, located above the title "Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)," is a customizable section of the model Form CMS- 10055, which the SNF may customize for its own use, consistent with the requirements of §70.4.2.2.

70.4.2.2 - Guidelines for Customizing the SNFABN Header (Rev. 1, 10-01-03)

The SNFABN's header should have the identifying information it requires as a billing entity. The SNF also must include at the top of the SNFABN's header its name, address, and telephone and TTY/TDD telephone numbers or directions for using its other telecommunication system for individuals with impaired speech or hearing. The SNF may elect to include its logo (if any). It is only within these general rules that the SNF can customize the header of the SNFABN.

70.4.3 - Body of SNFABN (Rev. 1, 10-01-03)

70.4.3.1 - Entering the Required Date(s) on the CMS-10055 SNFABN (Rev. 1, 10-01-03)

On the "Date of Notice" line of the SNFABN, the SNF must enter the delivery date, i.e., the date on which the SNF gave the notice personally to the patient or to the patient's authorized representative. Where personal delivery is not possible, the SNF is to include both the date it notified the patient or her or his authorized representative by telephone and the date it mailed the SNFABN.

70.4.3.2 - Specifications Required for the "Items or Services" Section of the SNFABN (Rev. 1, 10-01-03)

In the "Items or Services" section of the SNFABN, the SNF must specify the extended care items or services for which Medicare is expected not to pay (see §70.4.2). The specification must be in sufficient detail so that the patient understands precisely what extended care items or services may not be furnished and include any pertinent dates, e.g., "furnished on or after [date]". It is essential that the effective date(s) be included in the specification of services. The phrase "Items or Services" must also be included in this section. The SNF may customize (see §70.1.2) this section for its own use.

70.4.3.3 - Specifications Required for the "Because" Section of the SNFABN
(Rev. 1, 10-01-03)

In the "Because" section of the model SNFABN form, the SNF must give the specific reason(s) why it, the UR entity, the QIO, or the Medicare contractor expects Medicare to deny payment (see §70.4.2). The reason(s) cited must be in understandable lay language and must be sufficiently specific to allow the patient to understand the basis for the SNF's, the UR entity's, the QIO's, or the Medicare contractor's expectation that Medicare will deny payment. If necessary, the SNF is to gather evidence to the contrary from the physician and/or others in support of the coverage of such services (e.g., "our clinical assessment of your (the patient's) condition indicates that you can benefit from physical therapy services twice weekly, but that daily physical therapy services would not be beneficial"). The word "Because" must be included in this section. The SNF may customize (see §70.1.2) this section for its own use.

70.4.3.4 - Answering Inquiries About the SNFABN Notification
(Rev. 1, 10-01-03)

In the first bullet of the SNFABN that begins, "Ask us to explain …," the SNF is required to answer inquiries from a patient or the patient's authorized representative who requests further information and/or assistance in understanding and responding to the SNFABN, including the basis for the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that extended care items or services may not be covered. The SNF's refusal to respond to such inquiries may result in the SNFABN being invalidated and, thus, ineffective in protecting the SNF from liability.

70.4.3.5 - Providing Cost Estimation(s) for Items or Services on the SNFABN
(Rev. 1, 10-01-03)

On the first line of the second bullet of the SNFABN that reads, "Estimated Cost: $," the SNF may provide the patient with an estimated cost of the extended care items or services at issue. The patient may ask about the cost of the items or services and jot down an amount on this line. The SNF should respond to inquiries regarding the estimated cost to the best of its ability. The lack of an amount on this line, or an amount which is different from the final actual cost, does not invalidate the SNFABN; a SNFABN is not considered to be defective on that basis, unless otherwise specified in instructions to specific categories of users. In the case of a SNFABN that includes multiple extended care items or services, it is permissible for the SNF to give estimated amounts for the individual items or services rather than an aggregate estimate of costs.
Amounts may be provided either with the description of extended care items and services (i.e., in the "Items or Services" section) or on the "Estimated Cost" line.

70.4.3.6 - Providing Non-Medicare Insurance Information on the SNFABN (Rev. 1, 10-01-03)

The second line of the second bullet of the SNFABN that reads, "Your other insurance is:" is provided for a user, that is required by other instructions, to enter the name of the patient's other insurance (e.g., Medicaid, Medigap, employee plan, etc.). Any user, not otherwise required to do so, may enter this information at its own discretion.

70.4.3.7 - Providing Contractor Information on the SNFABN (Rev. 1, 10-01-03)

In the third bullet of the SNFABN that begins, "If in 90 days you have not gotten ... " the SNF is required to enter (on each of the lines so designated) the name, address, and telephone and TTY/TDD telephone numbers of the contractor to which the associated Medicare claim will be submitted. The information specified on these individual lines permits the patient or the patient's authorized representative to write or telephone the contractor directly should a determination on the associated Medicare claim not be received within 90 days.

70.4.3.8 - Required Guidelines in Preparation for Submitting Medicare Claims (Rev. 1, 10-01-03)

In the fourth bullet of the SNFABN that begins, "If you receive …," the SNF is required to submit to Medicare a claim for any and all extended care items or services furnished, except those that may be explicitly specified in other instructions. If, in compliance with other instructions, the SNF does not submit a claim to Medicare, the SNF is to delete or mark out the fourth bullet before delivering the SNFABN to the patient or the patient's authorized representative. In the instance where the patient or authorized representative requests submission of a claim for furnished extended care items or services not explicitly specified in instructions, the SNF is required to notify the patient or authorized representative when that claim has been submitted to the Medicare contractor. The SNF is prohibited from billing the patient or authorized representative for any items or services at issue until the contractor has determined coverage on the associated Medicare claim.

70.4.3.9 - Providing Appropriate Recipient Name on the SNFABN (Rev. 1, 10-01-03)

On the "Patient's Name:" line of the SNFABN, the SNF is to enter the name of the patient, not substituting the name of the authorized representative.

70.4.3.10 - Providing the Medicare Health Insurance Claim Number on the SNFABN (Rev. 1, 10-01-03)

On the "Medicare # (HICN):" line of the SNFABN, the SNF is to enter the patient's Medicare Health Insurance Claim Number (HICN). A SNFABN is not invalidated solely for the lack of a Medicare HICN unless the recipient of the SNFABN alleges that someone else of the same name signed the SNFABN and the Medicare contractor cannot resolve the matter with certainty.

70.4.3.11 - Providing Date of Signature on the SNFABN (Rev. 1, 10-01-03)

On the "Date" line of the SNFABN, the patient, or the patient's authorized representative should enter the date on which she or he signed the SNFABN. If the SNF writes in the date and the beneficiary or authorized representative does not dispute the date, that date is acceptable. A SNFABN is not invalidated simply because the date is typed or printed.

70.4.4 - Option Boxes (Rev. 1, 10-01-03)

70.4.4.1 - Selecting an Option on the SNFABN (Rev. 1, 10-01-03)

For Options 1 and 2 on the SNFABN, the patient or authorized representative is to personally select an option by making a mark in the chosen checkbox 1 or 2. SNFABNs with both checkboxes marked are unacceptable and will not protect the SNF from liability. If the patient or authorized representative marks the wrong checkbox accidentally or because either one has changed her or his mind, she or he should mark the correct checkbox and should cross out the erroneously marked checkbox and write her or his initials next to it. A new SNFABN is not required unless the patient or authorized representative changes her or his mind a second time.

70.4.4.2 - Prohibition of Pre-Selection of an Option on the SNFABN (Rev. 1, 10-01-03)

Any SNFABN on which the SNF pre-selects an option will not be acceptable as evidence of beneficiary notice. Pre-selecting options is prohibited and will invalidate the SNFABN.

70.4.4.3 - Effect of Beneficiary's Option Selection (Rev. 1, 10-01-03)

The patient or the authorized representative must select one option.

- If the patient selects Option 1, the patient may receive the subject extended care items or services, for which a demand bill must be submitted to Medicare for an official determination.

- If the patient selects Option 2 the patient has elected not to receive the subject extended care items or services.

70.4.5 - Proper Denial Paragraphs
(Rev. 2911, Issued: 03-14-14, Effective: 12-06-13, Implementation: 03-25-14)

The denial paragraphs (found below under Condition) cover common reason(s) why the extended care items or services are noncovered under Medicare. The SNF may use these denial paragraphs as inserts in the "Because" and "Items or Services" sections of the SNFABN (see §§70.4.3.2 and 70.4.3.3). Where no paragraph exists to explain the reason(s) why the extended care items or services are believed to be noncovered, the SNF is to develop new, or modify current, language to fit the situation. The SNF is to forward the newly prepared language to the Medicare contractor associated with processing its Medicare claims. The associated Medicare contractor will submit the SNF's language to CMS for review and, as appropriate, for inclusion in the MCPM.

Note: If applicable, the SNF is to substitute therapy and type of therapist for skilled nursing and skilled nurse. If applicable, the SNF is to substitute URC for "we" (e.g., "we or URC believe that the services you (the patient) received are noncovered."). If applicable, the SNF is to adjust the verb reflections or tense for those paragraphs containing admission denial information.

Condition: Nonskilled Care - Full Denial

Denial Paragraph: Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

Condition: Specific nonskilled service provided - no skilled care (full denial)

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service). This does not require the skills of a licensed nurse to perform the service or to manage your care. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

Condition: Specify nonskilled service provided - (partial denial)

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service) after (date). Since you no longer required skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning (date) is not covered under Medicare.

Condition: Observation and management of care plan - no significant change

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You needed skilled nursing care beginning (date) to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or of acute changes or complication in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe you stay after (date) is not covered under Medicare.

Condition: Observation and management of care plan - condition improved

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. Because of your condition, you needed a skilled nurse from (date) through (date) to evaluate and manage your care plan. Your condition has improved so the services you need can safely and effectively be given by nonskilled persons. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare after (date).

Condition: Teaching and training activities - partial denial

Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You had learned to perform the tasks ordered by your physician by (date) but the therapist continued services. Since you did not need skilled services after that date, we believe your stay is not covered under Medicare beginning (date).

Condition: Teaching and training activities - no skilled service

Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You needed only to be reminded to follow the physician's instructions. This does not require the skills of a professional nurse or therapist. Therefore, we believe that this service is not covered under Medicare.

Condition: Teaching and training activities - little or no progress

Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where

progressive learning is demonstrated. You received teaching and training for a reasonable time but demonstrated you were not able, at this time, to learn or make progress to perform the activities ordered by your physician. Therefore, we believe that skilled services are not covered under Medicare after (date).

Condition: Nursing not needed for foley care

Denial Paragraph: Medicare covers daily skilled nursing care related to the insertion, sterile irrigation and replacement of urethral catheter if the use of the catheter is reasonable and necessary for the active treatment of a disease of the urinary tract or for patients with special medical needs. Skilled nursing is not considered medically necessary when urethral catheters are used only for mere convenience or the control of incontinence. Since your catheter was inserted for convenience or the control or your incontinence, we believe that your care is not covered under Medicare.

Condition: Repetitive exercises - partial denial

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services. The medical information shows that the only therapy services you needed beginning (date) were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical complications which would have required that services be performed by a qualified therapist. We believe therapy services are not covered under Medicare after (date).

Condition: Therapy services for overall fitness and well-being. (Skilled therapy is physical therapy, occupational therapy, and/or speech-language pathology.)

Denial Paragraph: Medicare covers medically necessary skilled rehabilitative services when needed on a daily basis. The therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified (specify) therapist to perform and/or to supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, we believe your stay is not covered under Medicare.

Condition: Therapy to maintain function after a maintenance program has been established

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services to establish a safe and effective program to maintain your functional abilities. This program was established and beginning (date), the (specify) therapy services you received were to carry out this program. These services do not require the supervision or skills of a (specify) therapist and, therefore, we believe that the services are not/would not be covered under Medicare.

Condition: Specific skilled service is not reasonable and necessary (service not

specific or effective)

Denial Paragraph: Medicare covers medically necessary skilled care when needed on a daily basis. The (specify service(s)) you received is/are considered a skilled service by Medicare. However, based on the medical information provided, this/these service(s) is/are not considered a specific and/or effective treatment for your condition. Since the service(s) you received was/were not reasonable or necessary for the treatment of your condition, we believe your stay is not covered under Medicare.

Condition: Frequency not reasonable and necessary

Denial Paragraph: Medicare covers medically necessary skilled care when needed on a daily basis. Although (specify service) generally requires the skills of a (nurse, physical therapist, speech-language pathologist, occupational therapist), the frequency with which the service is given must be in accordance with accepted standards of medical practice. The service(s) you received is/are not normally needed on a daily basis. The medical information does not show medical complications which require the services to be performed on a daily basis. In this case, the services are not considered reasonable and necessary. Since you did not need skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

Condition: Skilled rehabilitation services not received daily - no skilled nursing

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. Although you required skilled (specify) therapy, you did not receive therapy on each day that it was available in the facility. Therefore, you do not meet the requirement for daily skilled rehabilitation services. Since you also did not need daily skilled nursing, we believe that your stay is not covered under Medicare.

Condition: Skilled nursing services not daily

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. Although you required skilled nursing services, you do/did not need them on a daily basis. Because you do/did not need daily skilled nursing or skilled rehabilitation, we believe Medicare will not cover your stay.

70.5 - Signature Requirements for SNFABN (Rev. 1, 10-01-03)

- On the "Signature of patient …" line of the SNFABN, the patient, or authorized representative, should sign her or his name.

- The patient may sign a SNFABN. In the case of a beneficiary who is incapable or incompetent, her or his authorized representative, as defined in §40.3.5, may sign a SNFABN.

- If the patient's (or authorized representative's) signature is absent from a SNFABN, in case of a dispute as to the patient's (or authorized representative's) receipt of the SNFABN, the Medicare contractor will give credence to the patient's (or authorized representative's) allegations regarding the SNFABN. However, if the patient (or the authorized representative) refuses to sign the SNFABN but demands extended care items or services, the guidance in §40.3.4.6 should be followed.
- The SNF must obtain the signed (containing the signature of the patient or authorized representative) and dated SNFABN with Option 1 or 2 selected as to the action the beneficiary wants to take, from the beneficiary, either in person or, where this is not possible, via return mail from the beneficiary or authorized representative as soon as possible after the SNFABN has been signed and dated. The beneficiary retains the patient's copy of the signed and dated SNFABN and returns the original. The SNF annotates the original of the SNFABN with the date of receipt from the beneficiary. The SNF is to return within 30 calendar days a copy of the SNFABN, including the date of its receipt, to the beneficiary for her or his records. The SNF retains the original SNFABN. These copies will be relevant in the case of any future appeal. Where the SNFABN is signed and dated in the presence of the SNF's staff or employee, the annotation of the date of the SNF's receipt of the signed and dated SNFABN may be made directly on both the original and patient's copy, and a second patient copy of the annotated original is not required.

- If a patient who chose "Option 2 No." later requests that a claim be submitted to Medicare, consistent with Option 1, the SNF should annotate its copy of the SNFABN with the date of its receipt of the new request and return a copy of the annotated SNFABN within 30 calendar days to the patient for her or his records.

- If the patient, or the authorized representative, refuses to sign the SNFABN and/or refuses to choose any option, the SNF should annotate its copy of the SNFABN, indicating the circumstances and persons involved. If this occurs, the SNF must decide whether or not to furnish the items or services to the patient in light of the fact that the patient has not agreed to be fully and personally responsible for payment for extended care items or services that are not covered by Medicare. If, under these circumstances (i.e., the patient refuses to pay but demands the items or services) the SNF decides to provide the extended care items or services, it should have a second person witness the provision of the SNFABN and the patient's refusal to sign. They should both sign an annotation on the SNFABN attesting to having witnessed said provision and refusal. Where there is only one person on site, the second witness may be contacted by telephone to witness the patient's refusal to sign the SNFABN by telephone and may sign the SNFABN annotation at a later time. The unused patient signature line on the

SNFABN form may be used for such an annotation; writing in the margins of the form is also permissible. (See §40.3.4.6.A.)

70.6 - Special Rules for SNFABNs
(Rev. 1, 10-01-03)

70.6.1 - Effect of Furnishing SNFABNs and Collection From Beneficiary
(Rev. 1, 10-01-03)

70.6.1.1 - Effective Notice
(Rev. 1, 10-01-03)

When SNFABNs are properly used by a SNF, the SNFABNs will protect the SNF from financial liability under §1879(a)(1) of the Act, which limits beneficiaries' financial liability. A beneficiary who has been given a proper written SNFABN, before an extended care item or service is furnished, reduced, or terminated, giving notice of the likelihood (or certainty) that Medicare will not pay for the specific item or service and the reason therefore and who, after being so informed, has agreed to pay the SNF for the extended care item or service, will be held financially liable. That is, that beneficiary will be found to have known in advance that Medicare will not pay, and the SNF will be free to bill and collect the related charges from the beneficiary.

70.6.1.2 - Defective Notice
(Rev. 1, 10-01-03)

Failure to meet the SNFABN standards and procedures will expose a SNF to the risk of potential financial liability for denied extended care items or services in cases where, in the absence of a proper SNFABN, the beneficiary would be held not to have known, nor to reasonably have been expected to have known, that her or his claims for the denied items or services he or she received, were likely to be denied by Medicare. Furthermore, any SNF held financially liable for failing to provide a SNFABN, failure to provide a SNFABN in a timely manner, or providing a defective SNFABN to a beneficiary will be precluded from collecting from the beneficiary and third-party payers which includes Medicaid. If a SNF is suspected of furnishing SNFABNs with the intent to induce or coerce referrals for other extended care items or services paid for by Medicare whereby anti-kickback statutes could be implicated, or if a SNF is suspected of issuing SNFABNs for any fraudulent, abusive, or otherwise illegal purposes, the Medicare contractor will refer the matter to the CMS regional office. A SNF that supplies a defective SNFABN (e.g., one which does not meet the standards in §40.3) will not be protected from financial liability. A beneficiary who received a defective SNFABN should be held not financially liable and the SNF that gave the defective SNFABN should be held financially liable.

70.6.1.3 - Collection From Beneficiary

(Rev. 1, 10-01-03)

When a SNFABN is properly executed and given timely to a beneficiary and Medicare denies payment on the related claim, the SNF must wait for the beneficiary to receive a denial Medicare payment determination before it can collect payment on the related claim. Medicare does not limit the amount that the SNF may collect from the beneficiary in such a situation. A beneficiary's agreement to "be personally and fully responsible for payment" means that the beneficiary agrees to pay out of pocket or through any other insurance that the beneficiary may have, e.g., through employer group health plan coverage, through Medicaid, or through other Federal or non-Federal payment source.

70.6.1.4 - Unbundling Prohibition
(Rev. 1, 10-01-03)

The SNFABNs may not be used to shift financial liability to a beneficiary in the case of services for which full payment is bundled into other payments; that is, where the beneficiary would otherwise not be financially liable for payment for an extended care item or service because Medicare made a bundled payment. Using a SNFABN to collect from a beneficiary where full payment is made on a bundled basis would constitute double billing. A SNFABN may be used to shift financial liability to a beneficiary in the case of extended care items or services for which partial payment is bundled into other payments; that is, where part of the cost is not included in the bundled payment made by Medicare.

70.6.2 - Reissuance of the SNFABN
(Rev. 1, 10-01-03)

A SNFABN, model Form CMS-10055, remains effective for the predicted denial it communicates to the beneficiary, without periodic reissuance, for an indefinite period as long as no triggering event occurs. If a triggering event does occur, then another SNFABN must be given immediately. A single SNFABN covering an extended course of treatment is acceptable provided the SNFABN identifies all extended care items and services for which the SNF, the UR entity, the QIO, or the Medicare contractor believes Medicare will not pay. If, as the extended course of treatment progresses, additional extended care items or services are to be furnished for which the SNF, the UR entity, the QIO, or the Medicare contractor believes Medicare will not pay, the SNF must separately notify the patient in writing (i.e., give the beneficiary another SNFABN) that Medicare is not likely to pay for the additional extended care items or services and obtain the beneficiary's signature on the SNFABN. One year is the limit for use of a single SNFABN for an extended course of treatment; if the course of treatment extends beyond one year, a new SNFABN is required for the remainder of the course of treatment. A SNFABN, once signed by the beneficiary, may not be modified or revised. When a beneficiary must be notified of new information, a new SNFABN must be given. The beneficiary may request a demand bill at any point in

her or his care.

70.6.3 - Acceptance or Rejection of SNFABN (Rev. 1, 10-01-03)

These instructions are to assist the Medicare contractor in advising SNFs with respect to their responsibilities in advising beneficiaries with respect to their rights and protections and in dealing with complaints from beneficiaries, or authorized representatives, about the lack of notice or defective notice. The SNF must timely answer inquiries from a beneficiary, or authorized representative, who requests further information and/or assistance in understanding and responding to the notice. The SNF must answer inquiries from a beneficiary, or authorized representative, regarding the basis for the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that extended care items or services may not be covered and, if requested by the beneficiary, or authorized representative, the SNF must give the beneficiary, or authorized representative, access to medical record information or other documents upon which the Medicare contractor based its assessment, to the extent permissible or required under applicable state law. Where state law prohibits such direct disclosure, the SNF must advise a beneficiary, or authorized representative, who has requested access to such information how to obtain that information from the SNF once a demand bill has been submitted. The SNF must respond timely, accurately, and completely to a beneficiary, or authorized representative, who requests information about the extent of the beneficiary's personal financial liability for extended care items or services for which the SNF, the UR entity, the QIO, or the Medicare contractor expects that Medicare may not, or may no longer, pay. If a beneficiary or authorized representative or a physician provides additional information with respect to Medicare coverage of the subject extended care items or services, the SNF must timely submit that additional information to the Medicare contractor. The Medicare contractor will reject a SNFABN in all cases in which the SNF does not meet these requirements.

70.6.4 - Effect of SNFABN on Beneficiary (Rev. 1, 10-01-03)

Under the statutory provision of LOL, a beneficiary who has received a proper SNFABN and who has agreed to pay for the specified extended care items or services will be fully and personally responsible for payment to the SNF if Medicare denies payment. The Medicare contractor will not hold a beneficiary who does not receive a SNFABN, or who receives a defective SNFABN (i.e., one that does not meet the requirements of these instructions, or one on which an option was pre-selected by the SNF) financially liable under the LOL provisions, unless there is clear and obvious evidence that the beneficiary knew or could reasonably have been expected to know that Medicare would not make payment (in which case, the Medicare contractor will hold the beneficiary financially

liable).

70.6.5 - Financial Liability (Rev. 1, 10-01-03)

A SNF that fails to comply with the SNFABN instructions risks financial liability and/or sanctions. LOL shall apply as required by law, regulations, rulings and program instructions thereunder. Additionally, sanctions under the Conditions of Participation (COPs), when authorized by law and regulations, may be imposed.

70.6.6 - Limitation on Liability (Rev. 1, 10-01-03)

The Medicare contractor will hold financially liable, under LOL, any SNF that failed to provide notice, or provided a defective notice, to a beneficiary in a particular case, to which LOL (§1879 of the Act) applies, unless the SNF can demonstrate that it did not know, and could not reasonably have been expected to know, that Medicare would not make payment, or there is clear and obvious evidence that the beneficiary knew that Medicare would not make payment. The SNF is to prepare and deliver to the patient (Medicare beneficiary) or her or his authorized representative a SNFABN when the SNF, the UR entity, the QIO, or the Medicare contractor expects that Medicare probably will not pay for, or will not continue to pay for, extended care items or services. If a SNF advises a beneficiary that, in its view, Medicare probably will not pay, but does so in a defective manner such that the beneficiary cannot fully exercise her or his rights and protections (which the Medicare contractor must assume to be the case when a SNFABN was not executed and delivered properly by the SNF), the Medicare contractor will consider that to be prima facie evidence that the SNF knew that Medicare would not make payment and not sufficient evidence to shift financial liability to the beneficiary. If a financially liable SNF collects from a beneficiary, the Medicare contractor shall implement the beneficiary protections under §100.

70.6.7 - Extended Care Items or Services Not Ordered by Physicians (Rev. 1, 10-01-03)

Medicare never pays for extended care items or services not ordered by a physician. No SNFABN is needed when extended care items or services are reduced or terminated in accordance with a physician's order, where a physician does not order the items or services at issue, or where the physician agrees in writing with the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that the extended care items or services are not necessary. The physician orders must be in writing and be entered into the beneficiary's record. The LOL provisions do not apply in these situations, but certain beneficiary protections under the COP do apply. An ABN (Form CMS-R-131) may be

required if a SNF has been acting as a supplier of Part B services or supplies outside a physician's plan of care.

70.6.8 - Regulatory Requirements (Rev. 1, 10-01-03)

- Under 42 CFR 483.10, "Condition of Participation: Resident rights."

70.6.9 - Standards (Rev. 1, 10-01-03)

70.6.9.1 - Establishing When Beneficiary Is On Notice of Noncoverage (Rev. 1, 10-01-03)

If the beneficiary has previously been informed in writing that the extended care items or services were noncovered as a result of a prior stay for the same condition, the beneficiary is liable, but only if it is clear that she or he (or her or his authorized representative) knew that the circumstances were the same. With this exception, the beneficiary is presumed not to have known, nor to have been expected to know, that the extended care items or services are not covered unless, or until, she or he receives notification from an appropriate source (see §70.6.9.2).

70.6.9.2 - Source of Beneficiary Notification (Rev. 1, 10-01-03)

- Where the SNF serves as the source of beneficiary notification.
    - The SNF on or before the day of admission furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary that the extended care item(s) or service(s) is noncovered.
    - The SNF, during the inpatient stay, timely furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying that the beneficiary no longer required covered extended care item(s) or service(s).
    - The SNF, when advised by the Medicare contractor that the beneficiary's covered extended care items or services have ceased, that very day furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary of the Medicare contractor's determination.
- Where the UR entity serves as the source of beneficiary notification.

- The UR entity (the group or committee responsible for conducting the SNF's UR) timely furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary that the extended care item(s) or service(s) is no longer covered.

- Where the QIO serves as the source of beneficiary notification.

  - The QIQ, where a beneficiary is in a swing bed, timely furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary that the extended care item(s) or service(s) is not covered or the item(s) or service(s) is no longer covered.

- Where a Medicare contactor serves as the source of beneficiary notification.

  - The beneficiary, or authorized representative, receives from the Medicare contractor her or his first notification of noncoverage (e.g., the Medicare contractor's denial notice).

70.6.9.3 - Determining the Notification Date for the Denial Paragraph (Rev. 1, 10-01-03)

SNFs are to insert in the denial paragraph, if applicable, of the SNFABN's "Because" section (see §70.4.5) the appropriate notification date. In instances where the:

- SNF determines prior to, or upon admission, that the services will not be covered, the SNF is to insert the date the determination was made;

- SNF determines that further services will not be covered, the SNF is to insert the first day on which the services are not covered, usually the day following the date of the SNFABN;
- UR entity advises the SNF that the beneficiary's stay was not medically necessary upon admission, the SNF is to insert the date of the first day on which the stay is not medically necessary;

- UR entity advises the SNF that a further stay is not medically necessary, the SNF is to insert the date of the first day on which the beneficiary's stay is not medically necessary; or

- Medicare contractor advises the SNF of the noncoverage of extended care item(s) or service(s), the SNF is to insert the date the covered item(s) and service(s) ended.

70.6.9.4 - Requesting a Medicare Decision
(Rev. 1, 10-01-03)

A bill for noncovered extended care items or services will only be submitted to Medicare if the beneficiary or her or his authorized representative so requests. Therefore, in order for a beneficiary or authorized representative to appeal the decision of noncoverage on a claim, she or he must request the SNF to submit the bill to Medicare. (See Chapter 29 of the Medicare Claims Processing Manual, "Appeals of Claims Decisions.")

70.7 – 70.13 New sections to be added

80 - Hospital ABNs (Hospital-Issued Notices of Noncoverage - HINN)
(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

Instructions for the Hospital ABN have been retracted. Instructions related to HINNs have been relocated as follows:

- Instructions regarding HINNs are found in this instruction, CR 3903, which precedes the placement of full instructions in Chapter 30.

- Instructions regarding hospital billing for cases involving QIO review will be relocated to a new section in Chapter 1 of this manual in the near future. Current procedures should not change in the interim.

Related instructions for QIOs can be found in the Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7.

100 - Indemnification Procedures for Claims Falling Within the Limitation on Liability Provision
(Rev. 1, 10-01-03)

Section 1879(b) of the Act provides that when a provider, practitioner, or supplier is held liable for the payment of expenses incurred by a beneficiary for noncovered items or services and such provider, practitioner, or supplier requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program indemnifies the beneficiary or other person(s).

Further, any such indemnification payments are considered overpayments to the provider, practitioner, or supplier.

A provider, practitioner, or supplier who is determined liable may not seek payment from a third party payer. (See §30.2.B.)

100.1 - Contractor and Social Security Office (SSO) Responsibility in Indemnification Claims
(Rev. 1, 10-01-03)

The contractor, SSO, RO, or central office may receive requests or inquiries concerning indemnification. However, a beneficiary or person(s) who made payment on behalf of the beneficiary to a liable provider usually visits his/her nearest SSO or deals directly with the contractor to file a request for indemnification.

Those offices are responsible for assisting beneficiaries or any person(s) in filing claims for indemnification.

100.2 - Conditions for Indemnification
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A beneficiary or any person(s) who assumed financial responsibility for payment is indemnified for claims filed if all of the following conditions are met:

- The contractor has determined that the beneficiary is without liability under authority of §1879 of the Act for items and services furnished by a provider, practitioner, or supplier;

- The contractor or the QIO has determined that the provider, practitioner, or supplier is liable under §1879 for the items and services furnished to the beneficiary. A provider, practitioner, or supplier is considered to have knowledge that payment will not be made under Medicare for items or services in a particular claim where the following evidence is established regarding the provider, practitioner, or supplier;

(1) Evidence that a provider, practitioner, or supplier knew, or could reasonably be expected to have known, of exclusion of items or services

- o General notice to the medical community regarding exclusion of certain items or services: e.g., colonic irrigation, acupuncture.

- o General notice to the medical community that services exceeding certain frequencies would be denied or subject to additional review, e.g., vitamin B12 injections, or nursing home visits more frequent than once a month.

- o Written notice to the particular provider, practitioner, or supplier that a type of service or item would be noncovered in all or certain circumstances.

A distinction must be maintained between coverage rules that specify that a type of

service or item would be not reasonable or necessary in all or certain circumstances, and utilization guidelines the contractor established to identify excessive services. Any written policies or other internal edits that are disclosed to a provider, practitioner, or supplier would not be considered as a "notice" of exclusion, since they are used for referring claims for further development rather than as rules to make a contractor coverage decision.

In addition to instances when the Medicare program has given notice, the allegation of a provider, practitioner, or supplier is not accepted without further verification in situations of potential program abuse involving a pattern of unnecessary services by a provider, practitioner, or supplier to a number of beneficiaries. When a provider, practitioner, or supplier frequently renders unnecessary services, i.e., services that significantly exceed the frequency with which the general medical community renders them, it is reasonable to expect the provider, practitioner, or supplier to know that such a pattern deviates from the standard practice.

(2) Evidence that provider, practitioner, or supplier did not have knowledge of exclusion of services.

In contrast to subsection 1, there may be situations where an assumption can be made that neither the beneficiary nor the provider, practitioner, or supplier had knowledge of exclusion, and liability can be limited by the reviewer without a statement by either party. In the following situations, further development would not be necessary:

a. The service is for a type of treatment that can be rendered only by a physician, but the contractor has not previously denied payment for the treatment, and it is not unreasonable that a particular physician might consider the treatment appropriate. In order to determine whether the services are reasonable and necessary, the contractor requests its physician consultant or CMS to advise whether the services are covered. This is a case for which there are no general coverage guidelines for the services; the contractor has not advised either the physician or the medical community regarding the coverage of the services; and the contractor is uncertain without expert consultation. In such a case, it may be presumed that neither the beneficiary nor the physician could have known that the services would be noncovered.

b. The item or service is ordinarily covered, but a question is raised as to whether it is reasonable and necessary in treatment of a particular diagnosis. Neither the provider, practitioner, or supplier nor the medical community has been advised that the item or service is not covered for that diagnosis. The case requires a determination by the contractor's medical consultant or is referred to CMS for guidance. As in example

(a), the liability of both parties should be limited.

c. The provider, practitioner, or supplier is newly arrived in the contractor service area, and the contractor has not yet communicated to the provider, practitioner, or supplier information in an existing general notice that the item or service is not covered, always or under certain circumstances.

Note: If any provider, practitioner, or supplier could reasonably be expected, by virtue of normal medical knowledge, to know that the service was unneeded, the presumption suggested in the above examples would not apply.

- The requester for indemnification has paid the provider, /practitioner or supplier all or some of the charges for items and services for which the beneficiary's liability has been waived under §1879 of the Act; and

- The requester seeks indemnification by filing a written statement prior to the end of the sixth month following:

  - The month in which payment was made to the provider, practitioner or supplier; or

  - The month in which the contractor advised the beneficiary that the beneficiary was not liable for the noncovered items or services, whichever is later.

The contractor extends the six month time limit if good cause is shown. The contractor uses the principles for determining good cause outlined in Chapter 29, "Appeals of Claim Decisions."

100.3 - Development and Documentation of Indemnification Requests (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

When the contractor receives a request or inquiry concerning indemnification directly from the beneficiary or the beneficiary's authorized representative, it must obtain the following information and documentation:

- Identifying information sufficient for the contractor to locate the claim(s) for noncovered items or services for which payment has been made to the provider, practitioner, or supplier by the beneficiary or other person and for which the liability of the beneficiary was limited. Ordinarily, the initial MSN or appeal determination suffices.

- A statement on Form SSA-795, "Statement of Claimant or Other Person," (see §100.10, Exhibit 4) to the effect that the requester paid the provider, practitioner, or supplier all or some of the charges for the noncovered items or services for which the beneficiary's liability was limited. The statement must specify the amount the requester has paid the provider, practitioner, or supplier. If the requester submits this information in a letter, the letter serves as the signed statement.

100.3.1 - Proof of Payment (Rev. 1, 10-01-03)

The following types of documentation are sufficient to establish that payment was made in the amount alleged:

- An itemized bill from the provider, practitioner, or supplier reflecting the items and services for which the provider, practitioner, or supplier has been found liable and has received payment along with the payer's cancelled check, money order receipt, or statement of receipt from the provider, physician, or supplier;

- A summary bill from the provider, practitioner, or supplier which pertains to the items and services for which the provider, practitioner, or supplier has been found liable and has collected from the beneficiary or other person along with the payer's cancelled check, money order receipt, or a statement of receipt from the provider, practitioner, or supplier showing the same total amount;

- The payer's cancelled check, money order receipt, or the statement of receipt from the provider, practitioner, or supplier if the contractor's records reflect the provider, practitioner, or supplier's charges for the items and services for which the provider, practitioner, or supplier has been found liable and these equal the total of the amount paid; or

- If the requester alleges that the provider, practitioner, or supplier did not furnish an itemized bill or a receipted statement and no other proof of payment is available, the contractor obtains a statement on Form SSA-795 to this effect from all parties involved, including the provider, physician, or supplier if possible. The statement should describe the circumstances, such as the manner of payment, and the reasons for not obtaining a receipt or any proof of payment. If there were any witnesses to the payment, the contractor obtains their statements on Form

SSA-795. The contractor refers any questions as to the acceptability of proof of payment to the RO.

When the beneficiary or other person on behalf of the beneficiary initially contacts the

SSO, that office sends the statements and evidence relevant to the indemnification claim to the appropriate contractor. If future contact with the beneficiary or other person is necessary, the contractor proceeds with a direct contact unless the assistance of the SSO is needed.

100.4 - Beneficiary Requests Indemnification, but Had No Financial Interest in the Claim

(Rev. 1, 10-01-03)

If a request for indemnification is received from the beneficiary but the beneficiary did not have full financial interest in the claim, then any other person(s) who made full or partial payment to the provider, practitioner, or supplier must be contacted to ascertain if that person wishes to file for indemnification.

If the individual declines to file for the indemnification payment, the SSO or contractor staff should assist in preparing a statement to that effect for the individual's signature. No payment is made in this instance; however, the contractor notifies all involved parties.

If more than one person helped pay the bill; e.g., sons and daughters of the beneficiary got together and each paid a portion of the bill; the contractor must determine the indemnification amount for each payer unless they all agree in writing that payment is to be made to one person. Explain this to the requester for indemnification in such instances.

100.5 - Questionable Indemnification Requests Procedure (Rev. 1, 10-01-03)

If the contractor receives a request for indemnification that does not appear to meet the conditions outlined in §100.2, and there is some uncertainty concerning the indemnification claim, it undertakes development to resolve the issues. If the issues cannot be adequately resolved, it obtains the assistance of the RO.

100.6 - Determining the Amount of Indemnification (Rev. 1, 10-01-03)

In accordance with §1879(b) of the Act, the contractor indemnifies the beneficiary or other person(s) for actual charges paid to a provider, practitioner, or supplier, rather than the usual allowable charges as determined by the Medicare program, PPS amounts, or established per diem rates that apply to certain provider, practitioner, or suppliers.

Additionally, §4096 of P.L. 100-203 (OBRA of 1987) revises certain limitation on liability requirements for indemnification under §1879(b) of the Act. A beneficiary qualifying for indemnification for denied items and services furnished on or after January 1, 1988 is no

longer responsible for paying deductible and coinsurance charges related to the denied claim. Where such indemnification is made, the contractor may not charge the beneficiary's Medicare utilization record for the denied items and services furnished.

100.7 - Notifying the Provider, Practitioner, or Supplier (Rev. 1, 10-01-03)

After the contractor has reviewed the claim for indemnification and the indemnification amount has been determined, it notifies the provider or physician/supplier of the proposed indemnification action. (A sample letter for these situations is contained in §100.10, Exhibit l.) The essential elements of this written notice are:

- An explanation of the items and services for which the provider or physician/supplier is liable with reference to the original notice to the provider or physician/supplier;
- A statement of the provision of §1879 which allows the program to indemnify the beneficiary and recover an overpayment from the provider, practitioner, or supplier;
- An explanation of the amount determined payable to the requester for indemnification;
- A statement that the amount the contractor has determined to be payable is paid to the requester and that it constitutes an overpayment to the provider, practitioner, or supplier which is to be recovered from future Medicare payments made to it;
- A statement encouraging the provider, practitioner, or supplier to refund any amount(s) already collected; and
- A reminder to the provider, practitioner, or supplier of his/her/its Medicare appeal rights.

If the provider, practitioner, or supplier does not respond to this notice within 15 days, the contractor makes payment to the requester in accordance with §100.8. If the provider, practitioner, or supplier disputes the indemnification or the amount to be paid, the contractor resolves any discrepancies before making payment. The payment process takes place even if the provider, practitioner, or supplier might appeal the contractor's initial determination which held the provider, practitioner, or physician liable and that appeal is still pending at the time payment of the indemnification amount is to take place. If the appeal decision reverses the initial determination, then adjustments are to be made at that time in the contractor and provider, practitioner, or supplier records. In all cases, the

contractor encourages the provider, practitioner, or supplier to refund any and all amounts collected to this point. If the provider, practitioner, or supplier chooses to refund any money collected, the contractor verifies that such a refund has actually been made to the requester.

100.8 - Making Payment Under Indemnification (Rev. 1, 10-01-03)

The contractor pays the indemnification amount if the provider, practitioner, or supplier does not make refund. It takes action to recover this amount as an overpayment from the provider, practitioner, or supplier. Also, it issues a letter of explanation to the requester for indemnification. (See §100.10, Exhibit 2 and Exhibit 3.) It sends a copy of this notice to the provider, /practitioner or supplier. The fundamental points of the notice include:

- Name of the provider, practitioner, or supplier and dates the services in question were rendered; and
- the amount of the indemnification check that the requester is to receive.

100.9 - Limitation on Liability Determination Does Not Affect Medicare Exclusion (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A determination to limit the liability of the beneficiary, as well as a finding that the physician's or supplier's liability may be limited and program payment made, does not change noncovered items or services into covered items or services. This means that the coverage question can still be raised as an issue at a level subsequent to an appeal determination that authorized program payment under §1879. It also means that, for purposes of determining an amount in controversy for an appeal, payment made under §1879 should be disregarded because coverage is still at issue and the amount charged is still in controversy.

100.10 - Exhibits (Rev. 1, 10-01-03)

1. Letter to Provider (Institutional Services).
2. Letter to Beneficiary Who Requests Indemnification (Institutional Services).
3. Letter to Someone Other Than Beneficiary Who Requests Indemnification.
4. Letter to Practitioner or Supplier (Noninstitutional Services)
5. Letter to Beneficiary Who Requests Indemnification (Noninstitutional Services)
6. Letter to Someone Other Than Beneficiary Who Requests Indemnification (Noninstitutional Services)
7. Form SSA-795, Statement of Claimant or Other Person.

Exhibit 1 - Letter to Provider
(Rev. 1, 10-01-03)

To: Provider

Dear Administrator:

Under §1879 of the Social Security Act, a Medicare beneficiary is relieved of the liability for certain noncovered services if the beneficiary did not know and could not reasonably have been expected to know that the items or services were not covered. Further, the law provides that the provider is liable if it is found that the provider knew or could reasonably have been expected to know that the items or services were not covered by Medicare.

On (date of limitation on liability notice), your facility was notified that the services provided to (beneficiary's name) during the period ( ) to ( ) were not covered under Medicare and that you were liable for these items and services.

(Requester's name) has submitted evidence that establishes that he paid your facility (amount paid) for the services received by (beneficiary's name). Because your facility has collected payment from (requester's name) after being determined liable for these services, §1879(b) of the Act requires that the Medicare program make direct payment (indemnification) to him for this amount, for which (beneficiary's name) is responsible.

A check in the amount of (amount of check) is being sent to (requester's name). This indemnification payment represents an overpayment to your facility and it will be withheld from future Medicare payments due you unless you advise this office that refund of the incorrect amount(s) has been made to (requester's name).

If you do not agree with the amount determined to have been paid you, please contact this office in writing within 15 days of the date of this letter.

Sincerely yours,

Exhibit 2 - Letter to Beneficiary Who Requests Indemnification
(Rev. 1, 10-01-03)

Dear (Beneficiary's Name):

Your request for refund of improper payment under §1879 of the Social Security Act (the limitation on liability provision) for the noncovered services provided you at (name of provider) from (date) to (date) has been received.

The evidence submitted establishes that, even though you were not responsible for the services you received, you paid (provider's name) (amount paid) for the services. Your

refund for these payments to (name of provider) has been calculated to be (indemnification amount). This figure represents full repayment for the charges you paid.

Your Medicare utilization record will not be charged where noncovered services were provided to you and you were determined not liable.

If you have any questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer to visit your local social security office, please take this letter with you.

Sincerely yours,

Exhibit 3 - Letter to Someone Other Than Beneficiary Who Requests Indemnification (Rev. 1, 10-01-03)

Dear (Person's Name):
Your request for refund of improper payment under Section 1879 of the Social Security Act (limitation of liability provision) for the noncovered services provided (beneficiary's name) at (name of provider) from (date) to (date) has been received.

It was determined that (beneficiary's name) was not liable for the services. The evidence you submitted establishes that you paid (provider) (amount paid) for the services provided (beneficiary's name). Your refund has been calculated to be (indemnification amount). This figure represents full repayment based on the expenses incurred by (beneficiary's name) in the amount of $(amount).

If you have any questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer, you may visit the local social security office. If you do, take this letter with you.

Sincerely yours,

Exhibit 4 - Letter to Practitioner or Supplier (Noninstitutional Services) (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Dear :

Under §1879 of the Social Security Act, a Medicare beneficiary is relieved of the liability for certain categories of noncovered items or services submitted as assigned claims if the beneficiary did not know and could not reasonably be expected to know that the items or services would not be covered. Further, the law provides that the practitioner or supplier

will be liable for the charges if it is found that he/she knew or could reasonably be expected to know that Medicare would not cover the items or services.

On (date of limitation on liability notification), you were notified that the following items or services provided to (name of beneficiary) were not covered and that you were liable for the charges for these items or services:

Description of Services	Date Provided

(Beneficiary or other person on behalf of beneficiary) has submitted evidence which establishes that he/she paid you $ for the items or services described above. Since it has been determined that you are liable for the items or services, §1879(b) of the Act requires that the Medicare program make payment (indemnification) to him/her for this amount. The amount of this payment will be treated as an overpayment to you and appropriate collection action will be taken unless you advise this office that refund has been made to (name of requester).

If you do not agree with the amount that (name of requester(s)) has established he/she paid you, please notify this office.

If we do not hear from you regarding the amount of the payment or that you will make refund directly by (15 days after date of this notice) payment will be made to (name of requester(s)) and action will be taken to collect the overpayment from you.

If you disagree with this determination, you may request a redetermination. The bases for such a request are: (1) that the services you provided were reasonable and necessary; (2) that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services; or (3) that you notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services. The request for redetermination must be in writing, and it must be filed within 120 days of the date you received the initial determination. If you have already received an adverse redetermination, you may request a reconsideration within 180 days of the date you received the redetermination. Our office will assist you if you need help in requesting a redetermination or a reconsideration. You need not file another request for a redetermination or a reconsideration if you already have taken such action.

Exhibit 5 - Letter to Beneficiary Who Requests Indemnification (Noninstitutional Services)
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Dear (Beneficiary's name):

Your request for indemnification (i.e., refund of improper payment) under §1879 of the Social Security Act (the limitation on liability provision) for the noncovered services provided you by (physician's/supplier's name) on (date) has been received.

The evidence submitted establishes that you paid (physician/supplier) (amount paid) for the noncovered services. It was determined upon redetermination that you were not liable for these charges. Your refund for these payments to (physician/supplier) has been calculated to be (indemnification amount). This figure represents full repayment for the charges you paid.

If your (physician/supplier) requests an appeal of this claim, it is possible that Medicare might find that your (physician/supplier) also did not know that Medicare would not pay for this service, or that this service should not have been denied. In that case, Medicare would pay your (physician/supplier) for this service. Also, you would be responsible for any deductible and coinsurance amounts. If this happens, you will receive a copy of the notice to your (physician/supplier).

Any future items or services of this type provided to you will be your responsibility because this is your notice that Medicare does not cover these services.

If you have further questions concerning this matter, please call this office. If you prefer to visit your social security office, please take this letter with you.

Exhibit 6 - Letter to Someone Other Than Beneficiary Who Requests Indemnification (Noninstitutional Services)
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Dear (Person's name):

Your request for indemnification (i.e., refund of improper payment) under §1879 of the Social Security Act (limitation on liability provision) for the noncovered services provided (beneficiary's name) by (name of physician/supplier) on (date) has been received.

It was determined upon redetermination that (beneficiary's name) was not liable for the charges.

The evidence establishes that you paid (physician/supplier) (amount paid) for the services provided (beneficiary's name). Your refund has been calculated to be (indemnification amount). This figure represents full repayment for the expenses incurred by (beneficiary's name).

If his/her (physician/supplier) requests an appeal of this claim, it is possible that Medicare might find that the (physician/supplier) also did not know that Medicare would not pay for this service, or that this service should not have been denied. In that case, Medicare would pay the (physician/supplier) for this service. Also, (beneficiary's name) would be responsible for any deductible and coinsurance amounts. If this happens, (beneficiary's name) will receive a copy of the notice to his/her (physician/supplier).

Any future items or services of this type provided to (beneficiary's name) will be his/her responsibility because this is your notice that Medicare does not cover these services.

If you have further questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer to visit the social security office, please take this letter with you.

Exhibit 7 - Statement of Claimant or Other Person (Rev. 1, 10-01-03)

Link to an exhibit of the Form SSA-795, "Statement of Claimant or Other Person," at:

http://www.ssa.gov/online/ssa-795.pdf.

110 - Contractor Instructions for Application of Limitation On Liability (Rev. 1, 10-01-03)

110.1 - Payment Under Limitation on Liability (Rev. 1, 10-01-03)

When it is determined during the course of a beneficiary's inpatient stay or during the patient's course of home health visits, or during a patient's course of treatment from a practitioner, physician or other supplier that the care is not covered but both the beneficiary and the provider of services are entitled to limitation on liability, the Medicare program may make payment for the noncovered services up to the date of notice and, if, for inpatient or home health services, the A/B MAC (A) or (HHH) determines that additional time is needed to arrange for post-discharge care, also for a "grace period" of l day after the date of notice to the provider or to the beneficiary, whichever is earlier. If it is determined that even more time is required in order to arrange post-discharge care, 1 additional "grace period" day may be paid for. (See §§30 and 40 for definition of notice.)

When the provider is given notice as described in §40.1, it is required to advise the beneficiary in writing of the determination on the same date it received the A/B MAC (A) or (HHH) notice. Where the provider fails to give the beneficiary such timely notice, the beneficiary is protected from liability until the beneficiary receives the notice.

For example, if a SNF received the A/B MAC (A)'s notice of noncoverage on February 15 but failed to advise the beneficiary until February 19, the beneficiary is protected from liability through February 19 - the date on which the beneficiary first received notice. However, the SNF is entitled to program payment only through the date - February 15 - on which it received notice, and for whatever "grace period" is allowed thereafter. In a case in which a SNF received the A/B MAC (A)'s notice on February 15 but failed to give the beneficiary notice until the next day - February 16 - the beneficiary and provider, if the A/B MAC (A) determines that additional time is needed to arrange post-discharge care, would be protected from liability under the "grace period" only for the additional day - February 16 - unless it is determined that even more time is required to arrange post-discharge care, in which case 1 additional "grace period" day may be paid for.

Note: The "grace period" is applicable only where circumstances have permitted program payment under §1879 of the Act, i.e., limitation on liability was applicable both to the beneficiary and the provider of services. Where the A/B MAC (A) or (HHH) concurs with a URC's decision that covered care has ended, any payments made during the "grace period" after the URC's notice are made under the authority of that statutory provision (§1814 of the Act) rather than under §1879.

110.2 - When to Make Limitation on Liability Decisions (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A - Initial Claims

In implementing the limitation on liability provision, the contractor makes a coverage decision before making a limitation on liability decision. Section 1879 of the Act

provides that limitation on liability can be allowed only in cases:

Where - (1) a determination is made that, by reason of §1862(a)(l) or (9) or by reason of a coverage denial described in subsection (g) of the Act, payment may not be made under Part A or Part B of this title for any expenses incurred for items or services furnished an individual by a provider of services... (Section 1879(a)(1) of the Social Security Act.)

Note: Subsection (g) refers to home health service denials under §§1814(a)(2)(C) and 1835(a)(2)(A), i.e., the patient is or was not confined to home; or the patient does or did not need skilled nursing care on an intermittent basis; and to hospice denials under §1861(dd)(3)(A) for services determined to be noncovered because the beneficiary was not "terminally ill".

Only after the contractor makes a decision that care is not reasonable or necessary, is custodial, is not reasonable and necessary for the palliation or management of terminal illness in hospice denials, or does not meet the homebound or intermittent nursing care requirements in home health service denials, or does not meet the "terminally ill" condition for hospice care, should a determination be made regarding limitation on liability. In every such case there will be two parts to the limitation on liability determination:

1. Whether and when the beneficiary knew or should have known that the services were noncovered, and

2. Whether and when the provider knew or should have known that the services were noncovered.

In any case where the provider gave the beneficiary notice that the services would be noncovered, the contractor will find that the provider knew that the services were noncovered.

B – Redetermination

At the redetermination level, again the contractor first makes a determination on the coverage issue. It considers the question of limitation on liability, if applicable, only if the initial adverse coverage decision is wholly or partially affirmed. (See Chapter 29, "Appeals of Claim Decisions," for discussion of the appeals process.)

110.3 - Preparation of Denial Notices
(Rev. 3560, Issued: 07-15-16, Effective: 10-17-16, Implementation: 10-17-16)

The provider and beneficiary notification procedures discussed in §§30 and 40 for determining liability do not change the instructions for the preparation and issuance of denial notices in Medicare Claims Processing Manual, Chapter 21, "Medicare Summary Notices."

Accordingly, in cases where the services are found to be custodial care or not reasonable and necessary, or in the case of HHA services, are denied for technical reasons under §1814(a)(2)(C) or §1835(a)(2)(A) of the Act, or in the case of hospice services, are denied for technical reasons under §1861(dd)(3)(A) of the Act:

An MSN denying the service(s) is sent to the beneficiary in cases where only the beneficiary is entitled to limitation on liability for any part of the noncovered stay. The notice advises the beneficiary of the beneficiary's entitlement to indemnification (see §100.) in the event the provider seeks payment from the beneficiary for the noncovered services. It uses MSN messages 50.36.2:

It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

All denial notices explain any decision regarding limitation on liability for either the provider, practitioner, or supplier or the beneficiary. (See Chapter 21, "Medicare Summary Notices.")

All denial notices, where either the beneficiary or provider, practitioner, or supplier has been found liable, must state that the provider has a right to a redetermination.

Providers, practitioners, and suppliers do not receive a separate written notification or copy of the MSN. Providers, practitioners, and suppliers must utilize the coding information (e.g., Remittance Advice Remark Codes) conveyed via the Remittance Advice (RA) to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

110.4 - Bill Processing
(Rev. 3187, Issued: 02-06-15, Effective: 03-06-15, Implementation: 03-06-15)

Where payment is made under the limitation on liability provision, because it was determined that both the provider, practitioner, or supplier and the beneficiary did not know and could not have been expected to know that services were not reasonable and

necessary, the usual deductible and coinsurance amounts apply.

When payment under limitation on liability is made for noncovered services, the contractor processes the bill in the same manner as any payment bill for covered services. For institutional services, if both the beneficiary and the provider have liability waived, the A/B MAC (A) charges the number of days or visits paid for under the limitation on liability provision to the beneficiary's utilization record. For noninstitutional services, it applies deductible and coinsurance, and, where applicable, statutory limits on services.

For situations where the contractor determines that the provider, practitioner, or supplier knew or should have known that the services were not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the services were not reasonable and necessary, the beneficiary qualifies for indemnification and is not responsible for paying deductible and coinsurance charges related to the denied claim. Additionally, where such indemnification is made, the contractor does not charge the beneficiary's Medicare utilization record days, visits, deductibles, or coinsurance (nor does it apply statutory limits, e.g., the psychiatric services Limit) for the denied items and services furnished.

The contractor follows the no-payment procedures in the relevant bill processing instructions in the following cases:

- Either the beneficiary or the provider/practitioner/supplier, or both knew or should have known that services were not covered.

- The provider, practitioner, or supplier knew or should have known that the services were not covered even though the beneficiary did not know. In these cases, the notice to the beneficiary will have informed the beneficiary that, even though no Medicare payment is being made, the beneficiary is not liable for the cost of the services and that the beneficiary may be indemnified for any improper payments the beneficiary made to the provider, practitioner, or supplier.

Where no Medicare payment is made because limitation on liability does not apply, or where payment ceases because of notice in a noncovered case, the normal provisions for no-payment situations apply.

For ancillary and outpatient services billed by institutional providers, the provider follows the instructions in Chapter 4 for hospitals, Chapter 7 for SNFs, and Chapter 10 for HHAs to process bills for these types of claims. Further, where ancillary services may not be paid under Part A because they were rendered in connection with a noncovered inpatient stay, the provider may still bill under Part B for ancillary services that may be covered under §1861(s)(3)-(9) of the Act.

110.5 - Contractor Review of ABNs (Rev. 1, 10-01-03)

110.5.1 - General Rules (Rev. 1, 10-01-03)

A. Generally, notifiers (physicians, practitioners, suppliers, providers) are not required to routinely submit copies of ABNs (CMS-R-131) to their Medicare contractor along with their claims (see §50.6.3). This is based on a rebuttable administrative presumption that a certain modifier (GA) or occurrence code (32) on the claims signify that notifiers are using the proper standard form CMS-R-131 and are preparing and delivering ABNs in compliance with the instructions in this Chapter.

B. Contractors may and should request CMS-R-131 ABNs (or any other ABN if the circumstances demand) be submitted to them for review in any circumstance in which the contractor is not confident that the administrative presumption is correct or in which the contractor has good reason to examine the ABNs of either particular notifiers or any class of notifiers. In the case where a contractor requests submission of copies of ABNs, the notifiers must submit such copies (see §50.6.3).

C. All Hospital ABNs (HINNs) will be reviewed by QIOs (see §80.5) and all HHABNs and SNFABNs will be reviewed when the contractor performs complex medical review of the demand bills.

110.5.2 - Situations in Which Contractor Review of ABNs is Indicated (Rev. 1, 10-01-03)

Circumstances involving ABNs (viz., with respect to claims on which there is any payment denial, that include either or both the GA modifier and occurrence code 32, and that do not include a copy of the ABN) in which the contractor should not be confident that the administrative presumption, viz., that notifiers are using the proper form and are properly preparing and delivering ABNs, is correct and should request submission of ABNs include, but are not limited to, the following:

A. Any claim where the contractor has any indication that the notifier may not have given proper notice, either no notice at all or defective notice, whether based on the contractor's experience (with the notifier or class of notifiers, or with the class of items or services), on beneficiary complaint, on any other plausible allegation, or on any other reasonable basis. (Contractors, of course, may not make baseless or capricious requests for routine submission of ABNs.)

B. Any claim for payment for more than one item or service. (In such cases, the contractor must ascertain which item(s) and/or service(s) the ABN specified and, therefore, to which claimed item(s) and/or service(s) the ABN applies with respect to assigning liability to the beneficiary. Liability is shifted to the beneficiary only if the ABN accurately specifies the items or services and if the specified expected reason for denial turns out to be the actual reason for denial.)

C. Any claim for an item or service for which there is a coverage frequency limit, and which includes one or more other items or services which are not frequency-limited. (Since ABNs may be given routinely for frequency-limited items and services, it is predictable that virtually all claims which include any frequency-limited item or service will include the GA modifier and/or occurrence code 32. When other, non-frequency-limited items or services are included on such a claim, any ABN specifying a frequency-limit as the expected reason for denial would not be applicable to the liability determination with respect to any item or service on such a claim that is not frequency-limited, nor with respect to any different frequency-limited item or service.)

D. Any claim for an item or service for which there is a coverage frequency limit and on which there is a payment denial on any basis other than exceeding the frequency limit. (Since the notifier can be reasonably expected to have given routine notice on the basis of the frequency limit, and since an ABN specifying a frequency-limit as the expected reason for denial would not be applicable to the liability determination with respect to any item or service on such a claim that is denied on any basis other than that particular frequency limit, such ABNs need to be reviewed for their correct application to any denial.)

E. Any claim about which there is any suspicion of fraud or abuse, whether with respect to the notifier, the category of notifiers, or the class of items or services involved.

110.5.3 - Other Reasons for Contractor Request for Copies of ABNs (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Other good reasons for contractors to request submission of copies of ABNs include, but are not limited to, the following:

A - Any need that arises from the appeals processes for documentation.

B - Any practical need to identify the particular items and/or services, dates of service, reasons for predicting Medicare denial of payment, or other pertinent facts about the beneficiary notification.

C - Any plausible allegation or dispute as to the form, content, or delivery of a particular ABN or a particular group of ABNs, e.g., all ABNs furnished by a particular notifier, all ABNs for a particular item, etc.

D - For the purposes of a data analysis, utilization study, or other investigation or study.

120 - Contractor Specific Instructions for Application of Limitation on Liability
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

120.1 - Documentation of Notices Regarding Coverage
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A critical step in the implementation of the limitation on liability provision is the distribution by contractors of notices regarding coverage issues to the medical community, or to specific segments of it, such as laboratories or certain physician specialty groups. An ongoing program of communication by contractors is essential. Timely communication of existing general notices to physicians and suppliers new to a contractor's service area is essential. The existence of written general notices will often determine the extent of program liability. As a minimum, the contractor should have a program for dissemination of the coverage guidelines published in the National Coverage Determinations Manual and the Medicare Benefit Policy Manual, as well as other guidelines contained in this manual for determining medical necessity and others issued from time to time in other CMS issuances.

120.2 - Availability of Coverage Notices to Operating Personnel
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

All review personnel should have ready access to a file of general notices regarding coverage for processing review cases involving the issue of limitation on liability.

In addition to general notices, the contractor must have a mechanism for identifying and locating correspondence with individual physician/suppliers regarding coverage of particular services or items. This mechanism should meet at least the following minimum requirements:

- The contractor must be able to determine if a practitioner or supplier has been sent an explanation, in lieu of, or in addition, to, a routine MSN denial notice, that a type of service or item is not reasonable and necessary. Such explanation may consist of a general notice or may be individual correspondence with the

physician/supplier such as is usually found in contractor correspondence units or comparable units. Claims history files can also be checked, but these are generally useful only when the identical item or service in question has been previously denied as not meeting the requirements of §1862(a)(1);

- A copy of such an explanation must be readily available to appeal personnel; and

- Procedures must be established requiring that a check of all files be made to determine if such an explanation was ever sent before the physician/supplier's liability is limited.

Once a physician/supplier receives an explanation of denial for an item or service after an appeal determination, that determination would be considered a notice that should be readily accessible for future use for a similar claim(s).

120.3 - Applicability of Limitation on Liability Provision to Claims for Outpatient Physical Therapy Services Furnished by Clinics
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A – General

The limitation on liability provision is applicable to claims for items or services furnished by a physician-directed outpatient physical therapy (OPT) clinic that are denied on the basis of §1862(a)(1).

The limitation on liability determination for OPT clinic claims will be made by contractors at the initial determination level, in accordance with §120.4. The procedures discussed in §120.2, second bullet , for determining a physician's/supplier's liability will be followed when processing this category of claims.

120.4 - Limitation on Liability Notices to Beneficiaries From Contractors
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The contractor adds MSN Limitation of Liability Message 50.36.2 to the MSN sent to the beneficiary (who is presumed not to have knowledge of nonpayment by Medicare) at the time of the initial determination.

To message 50.36.2, it also adds the following language:

Do not apply if your (doctor/supplier) told you in writing, before furnishing the service, that Medicare would not pay.

The contractor adds MSN Limitation of Liability Message 50.36.1 to the MSN sent to the beneficiary (who is held to have had knowledge of nonpayment by Medicare) at the time of the initial determination.

The contractor adds, from the Remittance Advice Remarks Codes, the Justification for Services Remark M25 to the RA sent to the physician/supplier (who is presumed to have knowledge of nonpayment by Medicare) at the time of the initial determination.

The contractor adds, from the Remittance Advice Remarks Codes, the Justification for Services Remark M38 to the RA sent to the physician/supplier who is held to be not liable because the beneficiary is held liable at the time of the initial determination.

In addition to the above, as appropriate, the contractor notifies both the beneficiary and the physician/supplier at the time of the initial determination of their appeal rights (this is contained on the back of the MSN and the RA).

120.5 - Contractor Redeterminations or Reconsiderations in Assignment Cases Conducted at the Request of Either the Beneficiary or the Assignee (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

In every appeal where the limitation on liability provision is applicable, the redetermination consists of two stages. The first stage is a new, independent and critical reexamination of the facts regarding the coverage issue. If the original decision regarding coverage was appropriate, the second stage is the decision whether to limit the liability of the beneficiary and, if so, whether to also limit the liability of the provider, practitioner, or supplier.

Redeterminations in assignment cases are conducted at the request of either the beneficiary or the assignee. Frequently, the redetermination request is received from only one of the parties, either the provider/physician/supplier or the beneficiary, and the only notice to the other party that a redetermination has been requested is a copy of the determination, i.e., after the fact. In a limitation on liability case, the parties may have adverse interests in the limitation on liability decision, since a provider, practitioner, or supplier may seek to show reason why the beneficiary's liability should not be limited in order to be able to collect his/her fee from the beneficiary. Therefore, when the contractor receives a request for a redetermination, it sends a notice that a request has been filed to the other party to the redetermination indicating that that party may submit additional

evidence. This is necessary to satisfy the statutory requirement that both parties be informed of their rights and privileges in the appeal process.

120.5.1 - Guide Paragraphs for Contractors to Use Where §1879 Is Applicable at the Redetermination Level (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The contractor uses the following paragraphs (in addition to other required appeal decision paragraphs) where the limitation on liability provision applies at the appeal level in the various situations shown below:

Situation I - To the provider, practitioner, or supplier when neither the provider, practitioner, or supplier nor the beneficiary is determined liable (program payment made under §1879 of the Act)

Paragraph(s):

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a physician/supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare, if neither the beneficiary nor the physician/supplier knew, or could reasonably have been expected to know, that the services were excluded. The services affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have concluded that these services are excluded under Medicare. However, since we find that neither (beneficiary's name) nor you knew, or could reasonably have been expected to know, that the services were excluded from coverage, the Medicare program will reimburse you under this provision of the law for the reasonable charge for the services, less any deductible and coinsurance. (Beneficiary's name) is responsible for any deductible and coinsurance amounts. Upon receipt of this notice, it will be considered that you now have knowledge of the exclusion of (description of service) for similar conditions, and this limitation of liability will not apply to future claims for the same or substantially similar services.

cc: Beneficiary

Situation II - To provider, practitioner, or supplier when the provider or practitioner or supplier is held liable

Paragraph(s);

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a provider or practitioner or supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare. Medicare may make payment under this situation if neither the beneficiary nor the

provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded. The services affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have determined that (beneficiary's name) did not know and could not have been expected to know, that these services were excluded from coverage. However, we find that (select applicable phraseology from the following): (l) based upon the claim of (date) which was a similar claim in which payment was denied; (2) (our notification to you of (date) that such services are excluded); (3) (or any other basis used to determine the provider, practitioner, or supplier to be liable)), you knew, or could have been expected to know, that these services were excluded. We also find that you did not notify the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services. Because of this, you are held liable for the full charges for the services.

We have also reviewed the claim with regard to the issue of whether the services were not reasonable and necessary. We found that the services were not reasonable and necessary.

If you disagree with this determination regarding your liability, on the basis that the services were necessary, or on the basis that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services, or on the basis that you notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services, you may request a reconsideration within 180 days of receipt of this notice, at which time you may present any new evidence that would have a material effect on this determination. Our office, or your social security office, will assist you if you need help in requesting a reconsideration.

cc: Beneficiary

Situation III - To the beneficiary when the beneficiary is held liable

Paragraph(s):

We have reviewed your claim for (description of the services). When we reviewed your claim, we considered two things. First, we considered whether the service you received was reasonable and necessary. Medicare will only pay for reasonable and necessary services. We found that the service was not reasonable and necessary.

Second, we considered whether you knew, or were told, that Medicare would not pay. Medicare would not hold you liable if you did not know and your (doctor/supplier) did not tell you in advance, in writing, that Medicare would not pay. In that case, we would

pay you any amount you pay or paid your (doctor/supplier) for the service. Our review shows that (choose one of the following to complete the sentence: (the (doctor/ supplier) told you in writing, before giving the service, that Medicare would not pay); (this service had been denied on other claims for you); OR (we told you in a letter dated (DATE) that Medicare would not pay for this service)). Since we believe you knew Medicare would not pay for this service, Medicare cannot pay. You are liable for the charges. If you do not agree with our decision, ask for a reconsideration from a Qualified Independent Contractor (QIC). The QIC will decide whether the service was reasonable and necessary. The QIC will also decide whether you knew, or were told, Medicare would not pay. You must ask for a reconsideration within 180 days of the date you receive this notice. At the reconsideration, you may present any new evidence which would affect our decision. If you need help, your social security office will help you request a reconsideration.

cc: Physician/Supplier

Situation IV - Rider paragraph to be included in the copy of the notice to the beneficiary when the physician/supplier is held liable

If you paid any amounts to (physician's/supplier's name) for this service, Medicare will pay you back the amount you paid. To get this payment, bring or send to this office three things. (1) A copy of this notice. (2) Your (doctor's/supplier's) bill. (3) A receipt or other proof you have paid the bill.

(See §§120.4 for handling requests for indemnification where payment has been made to a liable practitioner or supplier.)

130 - A/B MAC (A) and (HHH) Specific Instructions for Application of Limitation on Liability

(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

See §120.5.1 for guide language.

130.1 - Applicability of the Limitation on Liability Provision to Claims for Ancillary, Outpatient Provider and Rural Health Clinic Services Payable Under Part B

(Rev. 3187, Issued: 02-06-15, Effective: 03-06-15, Implementation: 03-06-15)

The following sections discuss how the limitation on liability provision is applied to claims involving ancillary, outpatient and rural health clinic services billed to the A/B MAC (A), where reimbursement is sought under Part B. The A/B MAC (A) determines whether

limitation on liability applies to these categories of claims when the basis for the denial is that the services were not reasonable and necessary (under §1862(a)(l) of the Act).

130.1.1 - Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services
(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

A presumption will be made that the beneficiary did not know that items or services are not covered unless there is evidence to the contrary. Indication on the claim that the beneficiary received proper advance beneficiary notice before receiving the noncovered ancillary, outpatient, or rural health clinic services is evidence to the contrary which rebuts the presumption in the beneficiary's favor. The definitions of proper "advance beneficiary notice" to the beneficiary are set forth in §40.3. Note that if the reason liability is at issue coincides with the end of coverage for a period of care in specific settings-- inpatient hospital, skilled nursing, home health, hospice or comprehensive outpatient rehabilitation facilities-- notification under the expedited determination process will be required as of July 1, 2005. See CR#3903 for preliminary information on the expedited process, including its interaction with liability notice policy (i.e., ABNs).

130.1.2 - Determining Provider Liability in Claims for Ancillary and Outpatient Services
(Rev. 1, 10-01-03)

The procedures in §30.2 apply for determining liability for providers. A provider may have its liability waived in an individual claim if it can establish that it did not know and could not have been expected to know that Medicare would not make payment for the items or services.

130.2 - Prior Hospitalization and Transfer Requirements for SNF Coverage as Related to Limitation on Liability
(Rev. 1, 10-01-03)

In order to qualify for post-hospital extended care services, the individual must meet the prior hospitalization and transfer requirements discussed in "Coverage of Extended Care Services Under Hospital Insurance," Chapter 8 of the Medicare Benefit Policy Manual. The following sections discuss the relationship of these requirements to the limitation on liability provision.

A. Three-Day Prior Hospitalization

Before Medicare can pay for post-hospital extended care services, it must determine whether the beneficiary had a prior qualifying hospital stay of at least three consecutive

calendar days. When a beneficiary's liability for a hospital stay is waived, the hospital days to which the limitation on liability applies **cannot** be used to satisfy the 3-day prior hospitalization requirement, since the services rendered during the days in question were found noncovered because they were not considered reasonable and necessary or because they constituted custodial care. (See "Coverage of Extended Care (SNF) Services Under Hospital Insurance," Chapter 8, of the Medicare Benefit Policy Manual for determining whether the 3-day prior hospitalization requirement is met.) If a beneficiary's hospital stay was partially covered, the A/B MAC (A) considers the covered portion of the stay in determining whether the SNF prior hospitalization requirement is met.

B. Transfer Requirements

1. Transfer Period

The A/B MAC (A) applies the limitation on liability provision where it determines that all the SNF care received during the period serving to satisfy the transfer requirements described in "Coverage of Extended Care Services Under Hospital Insurance," Chapter 8 of the Medicare Benefit Policy Manual, either constituted custodial care or was not reasonable and necessary.

Where the A/B MAC (A) determines that only the beneficiary's liability can be waived, the limitation on liability applies through the date of the notice to the beneficiary including any inpatient days beyond the transfer period. If the provider is also entitled to limitation on liability and program payment is possible under the limitation on liability provision, such payment is appropriate through the date of the notice and, if the A/B MAC (A) determines that additional time is needed to arrange for post-discharge care, for up to 24 hours after the date of notice to the provider or the beneficiary, whichever is earlier. If the A/B MAC (A) determines that even more time is needed to arrange post-discharge care, up to 24 additional hours may be paid for. (See §50.)

Where a beneficiary who is entitled to limitation on liability starts to require and receives reasonable and necessary or noncustodial services only **after** the expiration of the SNF transfer period, the beneficiary nevertheless may have his/her liability waived for days where such services were rendered, in addition to those days waived during the noncovered transfer period **but only through the date of notice to the beneficiary**. If the provider is also entitled to limitation on liability, program payment may be made under the limitation on liability provision through the date of notice of noncoverage and, if the A/B MAC (A) determines that additional time is needed to arrange for post-discharge care, for a "grace period" of l day thereafter. If the A/B MAC (A) determines that even more time is needed to arrange post-discharge care, 1 additional "grace period" day may be paid for. (See §50.) This payment is made because it is inequitable to waive liability for noncovered services rendered during the transfer period but not for a period thereafter (prior to notice) during which the beneficiary needed and received an

otherwise covered level of care.

2. Delayed Transfer Due to Medical Appropriateness

The law also provides for an extension of the usual 30-day time limit for transfer where the patient's condition makes it medically appropriate. ("Coverage of Extended Care Services Under Hospital Insurance," in the Medicare Benefit Policy Manual, Chapter 8.) However, if the A/B MAC (A) determines that such an extension is not allowable because an interval of more than 30 days for transfer to a SNF was not medically appropriate, it denies the SNF services because the transfer requirement was not met. The limitation on liability provision is not applicable in such a case.

130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds (Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

A. General

Payment for SNF and hospital claims may not be denied solely on the basis of a beneficiary's placement in a non-certified bed of a participating SNF or hospital. When requested by the beneficiary or his/her authorized representative, a provider must submit a claim to the A/B MAC (A) for services rendered in a non-certified bed. When the A/B MAC (A) reviews a claim for services rendered in a non-certified bed, it first determines whether the beneficiary consented to the placement. (See subsection C.) If the A/B MAC
(A) finds that the beneficiary consented, it denies the claim. If it finds that the beneficiary did not consent, it determines whether there are any other reasons for denying the claim. (See subsection D.) If there is another reason for denying the claim, the A/B MAC (A) denies it. However, if none of the reasons for denial exist, beneficiary liability must be waived as provided under §1879(e) of the Act and a further determination must be made as to whether the provider, rather than the Medicare program, must accept liability for the services in question. (See "Coverage of Extended Care Services Under Hospital Insurance" in the Medicare Benefit Policy Manual, Chapter 8.)

B. Provider Notice Requirements

When a SNF or hospital places a patient in a noncertified or inappropriately certified portion of its facility because it believes the patient does not require a covered level of care, or for any other reason, it must notify the patient (or authorized representative) in writing that services in a noncertified or inappropriately certified bed are not covered. The provider uses the appropriate notice specified in §70 of this chapter for SNFs or swing beds, §80 for inpatient hospitals, to advise the beneficiary of its decision to place

him/her in a noncertified bed, using language such as:

We are placing you in a part of this facility that is not appropriately certified by Medicare because (you do not require a level of care that will qualify as skilled nursing care/or covered hospital services under Medicare)/(or state any other reasons for the noncertified bed placement). Nonqualifying services furnished a patient in a noncertified or inappropriately certified bed are not payable by Medicare. However, you may request us to file a claim for Medicare benefits. Based on this claim, Medicare will make a formal determination and advise whether any benefits are payable to you.

(For related general billing requirements, see Chapter 1, §60 of this manual, or other chapters specific to the benefit being billed: Chapter 3 for inpatient hospitals and swing beds, Chapter 6 for swing bed PPS and inpatient SNFs, and Chapter 7 for outpatient SNFs.)

C. Determining Beneficiary Consent

The CMS presumes that the beneficiary did not consent to being placed in a noncertified bed. In order to rebut the presumption of lack of consent, the provider must indicate on the bill the date it provided the beneficiary with an ABN notifying the beneficiary that the accommodations would no longer be covered; and requested the beneficiary's signed acknowledgement (on the ABN) of having received such a statement. Moreover, in any case in which a Medicare beneficiary gives his/her consent to placement in a noncertified bed, the provider must, if requested by the A/B MAC (A) (contemplated only at an appeal level of claim processing), submit a copy of the ABN signed by the beneficiary to the A/B MAC (A), for a determination of the ABN's validity. The ABN must be signed by the beneficiary (provided he/she is competent to give such consent) or by the beneficiary's authorized representative. If the beneficiary or his/her authorized representative refuses to sign the form, the provider may annotate the file to indicate it presented the ABN to the beneficiary (or his/her authorized representative), but the beneficiary refused to sign. As long as the provider's ABN notifies the beneficiary of the likely Medicare noncoverage, the beneficiary's refusal to sign the ABN does not render it invalid. (See §40.3.4.6.) If any of the above requirements is not met, the A/B MAC (A) automatically determines the ABN is defective.

When the A/B MAC (A) receives a claim with an indication that the provider has provided the beneficiary or his/her authorized representative, with an ABN, the A/B MAC (A) denies the claim and notifies the beneficiary that §1879 limitation on liability cannot be applied because of the beneficiary's valid consent to be cared for in a noncertified or inappropriately certified bed. If the A/B MAC (A) determines that the ABN is not valid, the A/B MAC (A) processes the claim in accordance with §130.4.

If the beneficiary appeals the initial denial, the A/B MAC (A) obtains the ABN from the provider and determines whether it is valid. If the A/B MAC (A) determines that the ABN is invalid, it notifies the provider and the beneficiary that payment may be made to the extent that all other requirements are met.

D. Determining Whether Other Requirements for Payment are Met

Denials still are appropriate for any of the following reasons. The A/B MAC (A) must undertake the development needed to permit a determination as to whether:

- The patient did not receive or require otherwise covered hospital services or a covered level of SNF care;
- The benefits are exhausted;
- The physician's certification requirement is not met;
- There was no qualifying 3-day hospital stay (applicable to SNFs only); or
- Transfer from the hospital to the SNF was not made on a timely basis. (However, if transfer to an institution which contains a participating SNF is made on a timely basis, a claim cannot be denied solely on the grounds that the transfer requirement is not met because the bed in which the beneficiary is placed is not a certified SNF bed.)

The A/B MAC (A) denies cases falling within these categories under existing procedures. Also, if the beneficiary receives care in a totally nonparticipating institution, denial on the grounds that the beneficiary was not in a participating SNF or hospital is still appropriate.

130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed
(Rev. 594, Issued: 06-24-05, Effective: 07-01-05, Implementation: 07-01-05)

The A/B MAC (A) presumes that the provider properly notified the beneficiary of noncoverage, and that the beneficiary assented, if the claim includes the proper indicators of liability notification.

The following development occurs only if the beneficiary appeals the A/B MAC (A)'s decision that the beneficiary may not have liability waived because the provider gave him/her timely notice that Medicare would not cover the accommodation; and that he/she consented to being placed in a noncertified bed.

A. Beneficiary Liability

If the A/B MAC (A) determines that the beneficiary did not consent to placement in the noncertified bed within the participating facility (see §130.3.C), and that no other basis for denial of the claim exists (see §130.3.D), it finds the beneficiary not liable under §1879 of the Act.

B. Provider Liability

If the beneficiary is found not liable under §1879, liability may rest with the provider, or with the program. Liability rests with the Medicare program, unless any of the following conditions exist, in which case the provider is liable for the services.

The provider did not give timely written notice to the beneficiary of the implications of receiving care in a noncertified or inappropriately certified bed as discussed in §130.3.B;

The provider failed to provide the beneficiary with an appropriate ABN and/or did not attempt to obtain a valid consent statement from the beneficiary. (See §130.3.C.); or

The A/B MAC (A) determined from medical records in its claims files that it is clear that the beneficiary required and received services equivalent to a covered level of SNF care, or that constituted covered hospital services, and the provider had no reasonable basis for placing the beneficiary in a noncertified bed. Following are examples of situations in which it would be found that the provider did in fact have a reasonable basis to place a beneficiary in a noncertified bed:

Examples:

- The A/B MAC (A), a QIO, or Utilization Review Committee had advised the provider that the beneficiary did not require a covered level of SNF care or covered hospital services preadmission/admission;
- The beneficiary's attending physician specifically advised the provider (verified by documentation in the medical record) that the beneficiary no longer required a covered level of care or services; note that if covered care had previously existed, effective July 1, 2005, notification under the expedited determination process would be required (see §20 of this chapter);
- A beneficiary not requiring covered services had a change in his/her condition that later required a covered level of care or services and the provider had no certified bed available (of course, the SNF transfer requirement must be met, see the Medicare Benefit Policy Manual, Chapter 8.); or

- The A/B MAC (A) has other sufficient evidence to determine that the provider acted in good faith but inadvertently placed the beneficiary in a noncertified bed.

140 - Physician Refund Requirements (RR) Provision for Nonassigned Claims for Physicians Services Under §1842(l) - Instructions for Contractors and Physicians
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Following are the procedures for implementing §1842(l) of the Act. Under §9332(c) of OBRA 1986 (P.L. 99-509), which added §1842(l) to the Act, new liability protections for Medicare beneficiaries affect nonparticipating physicians.

140.1 - Services Furnished Before October 1, 1987
(Rev. 1, 10-01-03)

Before October 1, 1987, a physician who did not accept Medicare assignment was permitted to collect from a Medicare beneficiary his/her full charge for services which were subsequently denied because they were not reasonable and necessary under §1862(a)(1) of the Act, even though the beneficiary may not have known that Medicare would not pay for the services. This was in contrast to the rules applicable to assigned claims. Where a physician agrees to accept assignment (either on an individual claims basis or by entering into a Medicare participation agreement), the physician is effectively precluded by the indemnification procedures under the limitation of liability provision from receiving payment for services that are not reasonable and necessary if it is established that the physician knew or should have known that Medicare would not pay for the services and the beneficiary did not. However, under the limitation of liability provision, program payment may be made to the physician if neither the physician nor the patient knew, nor could reasonably have been expected to know, that Medicare would not pay for the items and services.

140.2 - Services Furnished Beginning October 1, 1987
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Under §1842(l) of the Act, effective for services furnished on or after October 1, 1987, nonparticipating physicians who

1. Do not accept assignment,

2. Do not claim payment after the death of the beneficiary, and

3. Do not bill under the indirect payment procedure must refund to beneficiaries

any amounts collected for physicians' services which are denied because they are not reasonable and necessary under §1862(a)(1).

This provision is applicable in any case in which the contractor denies payment or reduces the level of payment on the basis of §1862(a)(1). In the latter situation, there is, in effect, a denial of the more extensive service or procedure on the basis that it is not reasonable and necessary under §1862(a)(1), even though Medicare payment is made for the less extensive service or procedure (e.g., an intermediate office visit is allowed as a brief office visit). Where a reduction in the level of payment occurs, the physician must refund to the beneficiary any amounts he/she collects which exceed his/her maximum allowable actual charge (MAAC) for the less extensive procedure. Of course, in the unusual case where the physician's MAAC for the less extensive service equals or exceeds his/her actual charge for the more extensive service, no refund is required.

Section 1842(l) of the Act applies only to physicians' services subject to the Medicare Economic Index (MEI). Certain services, such as those involving injections that can be given by a paramedical person other than a physician (e.g., pneumococcal and hepatitis vaccine injections) which may be denied under §1862(a)(1) are not physicians' services for purposes of the MEI. Therefore, denials of payment on the basis of §1862(a)(1)(B) of the Act for those services are not subject to §1842(l) refund requirements. Additionally, services of physician extenders (e.g., physician's assistants, nurse practitioners, MEDEXes, etc.) are not physicians' services and are not subject to §1842(l) refund requirements. The application of §1842(1) refund requirements on the correct statutory basis, i.e., only on the basis of §1862(a)(1), and only to physicians' services subject to the MEI, is essential. Incorrect application improperly takes away physicians' rights to bill beneficiaries for denied services and incurs unnecessary expenses for review, development, and appeals.

140.3 - Time Limits for Making Refunds (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A required refund must be made within specified time limits. Physicians who knowingly and willfully fail to make refund within these time limits may be subject to civil money penalties and/or exclusion from the Medicare program. Under §1842(1) , a refund of any amounts collected must be made to the beneficiary within the following time limits:

- If the physician does not request an appeal of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the physician receives notice of the initial determination. (See §140.6 for notice requirements.); or

- If the physician requests an appeal within 30 days of receipt of the notice of the

initial determination, the refund must be made to the beneficiary within 15 days after the date the physician receives the notice of the appeal determination.

140.4 - Situations Where a Refund Is Not Required (Rev. 1, 10-01-03)

Under §1842(1), a refund is not required of the physician if either of the following conditions is met:

1. The physician did not know and could not reasonably have been expected to know that Medicare would not pay for the services because they were not reasonable and necessary. To determine whether the physician knew, or could reasonably have been expected to know, use the rules for determining physician liability under §1879. (See §30.2.); or

2. Before the service was furnished, the physician notified the beneficiary in writing of the likelihood that Medicare would not pay for the specific service and, after being so informed, the beneficiary signed a statement agreeing to pay the physician for the service.

To qualify for waiver of the refund requirements of §1842(1), the advance notice to the beneficiary must be in writing, must clearly identify the particular service, must state that the physician believes Medicare is likely to deny payment for the particular service, and must give the physician's reason(s) for his/her belief that Medicare is likely to deny payment for the service. The Advance Beneficiary Notice (ABN, Form CMS-R-131), given in compliance with §40.3 and §50, satisfies the statutory requirements for the physician's advance notice and the beneficiary's agreement to pay.

140.5 - Appeal Rights (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Nonparticipating physicians have the same rights to appeal the contractor's redetermination in an unassigned claim for physicians' services if the contractor denies or reduces payment on the basis of §1862 (a)(1) as they or participating physicians have in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the physician knew or should have known that Medicare would not pay for the service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the service or, if so informed, did not sign a statement agreeing to pay. In addition to the beneficiary's right to appeal the contractor's decision to deny or reduce payment on the basis of §1862 (a)(1), the beneficiary becomes a party to any request for appeal filed by the physician. Since the beneficiary and the physician may have adverse interests in a decision

regarding refund, it is essential to notify the beneficiary in any case in which the physician requests an appeal of the denial or reduction in payment or asserts that a refund is not required because one of the conditions in §140.4 is met. (See Chapter 29, "Appeals for detailed appeals instructions.")

140.6 - Processing Initial Denials
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

In any unassigned claim for physician's services furnished on or after October 1, 1987, in which the contractor denies or reduces payment on the basis of §1862(a)(1), the contractor will send separate notices to both the beneficiary and the physician. In some cases, the beneficiary (or physician) may submit a copy of an ABN which satisfies the requirements in §140.4. The contractor should not make an automatic finding that the service is not reasonable and necessary merely because the beneficiary has submitted an ABN. The fact that there is an acceptable ABN must in no way prejudice the contractor's determination as to whether there is or is not sufficient evidence to justify a denial under §1862(a)(1). In the case where there is an acceptable ABN, the contractor will mail a standard denial MSN notice to the beneficiary. In the absence of an acceptable ABN, and depending on whether there is a full denial or a partial reduction in payment, the contractor will include, in addition to one of the "medical necessity" denial notices, one of the following notices in the MSN sent to the beneficiary.

140.6.1 - Initial Beneficiary Notices
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Notice 1 - Full Denial

If the doctor should have known that Medicare would not pay for the denied services and did not tell you in writing before providing the services, you may be entitled to a refund of any amounts you paid.
However, if the doctor requests an appeal of this claim within 30 days, a refund is not required until we complete our appeal. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your doctor's office.

Notice 2 - Reduction in Payment

If the doctor should have known that Medicare would not pay for the more extensive service and did not tell you this in writing before providing the service, you may be entitled to a refund of any amount you paid which is more than the doctor is allowed by law to charge under Medicare for the less extensive service. However, if the doctor requests an appeal of this claim within 30 days, a refund is

not required until we complete our appeal. If you paid for the more extensive service and do not hear anything about a refund within the next 30 days, contact your doctor's office.

In addition, add the following paragraph:

You could have avoided paying $, the difference between the maximum amount the doctor or supplier is allowed to charge and the amount Medicare approved for the lesser service, if the claim had been assigned.

140.6.2 - Initial Physician Notices
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Include in the notice to the physician the following:

- The patient's name and health insurance claim number;
- A description of the service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN; and
- Depending on whether the beneficiary submitted a copy of an acceptable ABN with his/her claim, include in the notice to the physician one of the following:

Notice 1 - Advance Beneficiary Notice Received Prior to Initial Determination

(The service identified above has been denied because/although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service. Since you informed the beneficiary in writing prior to furnishing the service that Medicare was likely to deny payment for the (more extensive) service and the beneficiary signed a statement agreeing to pay, the beneficiary is liable for (this/the more extensive) service.

Or

Notice 2 - Advance Beneficiary Notice Not Submitted

(The service identified above has been denied because/Although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service).

If you have collected (any amount from the patient/any amount that exceeds your maximum allowable actual charge (MAAC) for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service; or
- If you notified the beneficiary in writing before providing the service that you believed that Medicare was likely to deny the service, and the beneficiary signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the contractor was wrong in its determination that Medicare does not pay for this service, you should request an appeal of this determination by the contractor within 30 days of receiving this notice. Your request for appeal should include any additional information necessary to support your position.

If you request an appeal within this 30 day period, you may delay refunding the amount to the beneficiary until you receive the results of the appeal. If the appeal determination is favorable to you, you do not have to make any refund. If, however, the appeal is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable appeal decision.

The law also permits you to request an appeal of the determination at any time within six months of receiving this notice. An appeal requested after the 30 day period does not permit you to delay making the refund.
Regardless of when an appeal is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(1) of the Social Security Act. Section 1842(1) specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program.

If you have any questions about this notice, please contact (Contractor contact, telephone number).

The contractor will ensure that the telephone number puts the physician in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

Note: These procedures do not apply to claims the contractor automatically denies under the A/B link procedures. In those cases, the QIO is responsible for notifying the beneficiary and physician of the refund requirements of §1842(1) and making the refund determination where appropriate.

140.7 - Processing Beneficiary Requests for Appeal (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a beneficiary requests an appeal of the initial denial or reduction in payment, the contractor will process the appeal in the normal fashion except that, where the appeal results in a reversal to full or partial payment, the contractor will include the following special paragraph in the appeal notice sent to the beneficiary:

The doctor who furnished this service has been informed of this decision and advised that he/she may collect (his/her full charge for the service/up to the maximum amount he/she is allowed by law to charge under Medicare for the less extensive service for which payment has been made).

If the reversal is for the less extensive service, the contractor will incorporate in the notice the following:

You could have avoided paying $, the difference between the maximum amount the doctor is allowed to charge and the amount Medicare approved for the lesser service, if the claim had been assigned.

The contractor will send the physician who furnished the service a separate notice which clearly identifies the service for which full or partial payment is being made (i.e., includes the patient's name, health insurance claim number, a description of the service billed by procedure code, date and place of service, and amount of the charge. Where only partial payment is being made, the contractor will clearly indicate the less extensive service for which payment has been made). The contractor will include the following language:

You were previously advised that Medicare payment could not be made for this service. However, after reviewing this claim, we have determined that payment may be made (for a less extensive service). Therefore, if you have already refunded the amounts you collected from the beneficiary for this service, you may recollect (these amounts/any

amounts which do not exceed your maximum allowable actual charge (MAAC) for the less extensive service for which payment has been made).

140.8 - Processing Physician Requests for Appeal (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a physician requests an appeal, the contractor will notify the beneficiary as discussed in §140.5. The appeal process consists of three stages, even though the physician may be contesting only one issue (e.g., the physician may assert that he/she did not know, and could not have reasonably have been expected to know, that Medicare would not pay for the services).

140.8.1 - Appeal of the Denial or Reduction in Payment (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The first part of the appeal is a new, independent, and critical reexamination of the facts regarding the denial or reduction in payment. If the contractor finds that the initial denial or reduction in payment was appropriate, the contractor will go on to §140.8.2.

140.8.2 - Beneficiary Given ABN and Agreed to Pay (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A physician who has given the beneficiary an ABN and has obtained the beneficiary's signed statement agreeing to pay, is not required to make a refund. If the physician claims to have given an ABN to the beneficiary, the contractor will ask the physician to furnish a copy of the signed ABN. The contractor will examine the ABN to determine whether it meets the guidelines in §140.4. In the absence of acceptable evidence of advance notice, the contractor will go on to §140.8.3.

140.8.3 - Physician Knowledge (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

In determining whether the physician knew, or could reasonably have been expected to know, that Medicare would not pay for the services, the contractor will apply the same rules that are applicable in determining physician liability under §1879 of the Act. (See
§30.2.)

140.9 - Guide Paragraphs for Inclusion in Appeal Determination (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The contractor, upon completion of its appeal, will send the physician an appeal notice

and send a copy to the beneficiary. If the initial payment determination is reversed to full or partial payment, the contractor will include in the appeal notice the physician notice language required in §140.7. Otherwise, the contractor will include one of the following paragraphs concerning refund.

Paragraph 1. Refund Not Required - Beneficiary Was Given Advance Beneficiary Notice and Agreed to Pay

Under §1842(l) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not required if, prior to furnishing the services, the physician notified the beneficiary in writing that Medicare would not pay for the services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that you informed the beneficiary in advance that Medicare does not pay for the above services and the beneficiary agreed to pay for them. Therefore, you are not required to make a refund in this case. The beneficiary has been sent a copy of this notice.

Paragraph 2. Refund Not Required - Physician Did Not Know That Medicare Would Not Pay For the Services

Under §1842(1) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not necessary if the physician did not know, and could not reasonably have been expected to know, that Medicare does not pay for the services. After reviewing this claim, we find that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the above services. Therefore, you are not required to make a refund in this case. Upon your receipt of this notice, it is considered that you now have knowledge of the fact that Medicare does not pay for (description of services) for similar conditions. The beneficiary has been sent a copy of this notice.

Paragraph 3. Adverse Action on Denial - Refund Required

Under §1842(1) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. A refund is not required if (1) the physician did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services; or (2) the physician notified the beneficiary in writing before furnishing the services that Medicare would not pay for the services and the beneficiary signed a

statement agreeing to pay for them. After reviewing this claim, we have determined that neither of these conditions is met in this case. You must therefore refund any amount you collected for these services within 15 days from the date you receive this notice. A refund must be made within 15 days from receipt of this notice for you to be in compliance with the law. If we paid for a less extensive procedure, you need refund only the amount which exceeds your maximum allowable actual charge (MAAC) for the less extensive procedure. The beneficiary has been sent a copy of this notice. Physicians who knowingly and willfully fail to make appropriate refunds may be subject to assessments of double the violative charges, civil money penalties (up to $2000 per violation), and/or exclusion from the Medicare program for a period of up to 5 years.

140.10 - Physician Fails to Make Refund
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Under §1842(1) of the Act, a physician who knowingly and willfully fails to make refund within the time limits in §140.3 may be subject to sanctions (i.e., civil money penalties and/or exclusion from the Medicare program). Generally, the failure of a physician to make a refund comes to the contractor's attention as a result of a beneficiary complaint to the contractor, Social Security Administration (SSA), or CMS. If necessary, the contractor will contact the beneficiary to clarify the information in the complaint and to determine the amount the beneficiary paid the physician for the denied services. If the contractor determines that a physician failed to make a refund, it will contact the physician in person or by telephone to discuss the facts of the case. The contractor will attempt to determine why the amounts collected have not been refunded and will explain that the law requires that the physician make refund to the beneficiary and that if he/she fails to do so, the OIG may impose civil money penalties and assessments, and sanctions. The contractor will make a dated report of contact and include the information relayed to the physician and the physician's response. The contractor will recontact the beneficiary in 15 days to determine whether the refund has been made. When the amount in question is $300 or more or where there are at least three outstanding violations by the physician, the contractor will contact the Sanctions Coordinator in the appropriate field office of the OIG by telephone to discuss whether referral to OIG is appropriate. If the case should be referred, the contractor will make the referral to the regional OIG Sanctions Coordinator in accordance with the procedures following. The contractor should not make a referral until the physician's appeal rights have been exhausted, or until the time limit for an appeal has passed.

140.11 - OIG Referral Procedures
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

The contractor will include in the sanction recommendation to the OIG/FO (to the extent appropriate) the following:

- Identification of the Subject - The subject's name, address and a brief description of the subject's special field of medicine.

- Origin of the Case - A brief description of how the violations were discovered.

- Statement of Facts - A statement of facts in chronological order describing each failure to comply with the refund requirements in §1842(1).

- Documentation - Copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiary and the physician regarding the physician's failure to make refund.

- Other Significant Issues - Any information that may be of value in the event of a hearing to bar a physician from receiving Medicare payment.

140.12 - Imposition of Sanctions (Rev. 1, 10-01-03)

Section 1842(1)(3) of the Act provides that if a physician knowingly and willfully fails to make a required refund, the Secretary may impose the sanctions provided in §§1842(j)(2) of the Act. These include assessments of double the violative charges, civil money penalties (up to $2000 per violation), and/or exclusion from the Medicare program for a period of up to five years. However, sole community physicians and physicians who are the sole source of an essential specialty are not excluded from the program. The OIG makes determinations to levy a monetary penalty or program exclusion based upon a failure to make a refund.

150 - DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) - Instructions for Contractors and Suppliers (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Following are the procedures for implementing §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act. Under §132 of SSAA-1994 (Social Security Act Amendments of 1994, P.L. 103-432) which adds §1834(a)(18) to the Act, and under §133 of SSAA-1994 which adds §1834(j)(4) and §1879(h) to the Act, new liability protections for Medicare beneficiaries affect suppliers of medical equipment and supplies. All suppliers who sell or rent medical equipment and supplies to Medicare beneficiaries are subject to the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act. Beneficiaries' liability for payment for certain items and services, that is, for otherwise covered medical equipment and supplies as defined in §150.10 , which are furnished on or after January 1, 1995, and for which Medicare payment is denied for one of several reasons specified below, may be limited as

follows. For both assigned and unassigned claims, for which the supplier knew or should have known of the likelihood that payment would be denied (that is, the supplier is held to be liable) and for which the beneficiary did not know, the beneficiary has no financial responsibility and the refund provisions of the Act apply in virtually all cases. The single exception to this rule of applicability is that, with respect to medical equipment and supplies for which the supplier accepted assignment and for which payment is denied because the item or service is not medically reasonable and necessary under §1862(a)(1) of the Act, the §1879 Limitation on Liability provisions which applied to such denials prior to January 1, 1995, still apply. The refund provisions do not apply to these denials.

In claims for medical equipment and supplies, payment reductions may be based on partial denials of coverage for additional expenses not attributable to medical necessity. A medical necessity "partial denial" is the denial of coverage for the unnecessary component of a covered item or service, when that component is in excess of the beneficiary's medical needs. Any such excess component is not medically reasonable and necessary and therefore, under §1862(a)(1) of the Act, it is not covered. A partial denial may be used to base payment on the least costly, medically appropriate, alternative. The beneficiary liability protections of §1879 and of §1834(j)(4) of the Act apply to any payment reductions due to partial denials of coverage for medical equipment or supplies on the basis of medical necessity under §1862(a)(1) of the Act. (See §140 for its similar provision for the applicability of the refund requirements under §1842(l) of the Act to partial denials of coverage for physicians' services.)

When the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act apply and the supplier is held to be liable, a required refund must be made on a timely basis. Suppliers which knowingly and willfully fail to make refund within specified time limits may be subject to civil money penalties and/or exclusion from the Medicare program.

Refund is not required if the supplier is held not to be liable, that is, if it is held that the supplier did not know and could not reasonably have been expected to know that Medicare would not pay on the basis of §1834(a)(17)(B), §1834(j)(1), §1834(a)(15), or §1862(a)(1) of the Act, or if it is held that, before the item or service was furnished, the beneficiary was informed by the supplier that Medicare would not pay and the beneficiary agreed to pay for the item or service. In any case where the supplier is held not to be liable, the beneficiary is liable for payment.

150.1 - Definition of Medical Equipment and Supplies (Rev. 1, 10-01-03)

The following definitions of medical equipment and supplies control the application of the provisions of this section.

150.1.1 - Unassigned Claims Denied on the Basis of the Prohibition on Unsolicited Telephone Contacts
(Rev. 1, 10-01-03)

For unassigned claims denied on the basis of the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act, the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act; and
- Medical supplies, as described in §1861(m)(5) of the Act, including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care.

150.1.2 - Unassigned Claims Denied on the Basis of Not Being Reasonable and Necessary
(Rev. 1, 10-01-03)

For unassigned claims denied on the basis of not being reasonable and necessary under §1862(a)(1) of the Act; or Medicare payment being denied in advance under §1834(a)(15) of the Act; the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act; and
- Such other items as the Secretary may determine.

150.1.3 - Unassigned Claims Denied on the Basis of Failure of the Supplier to Meet Supplier Number Requirements
(Rev. 1, 10-01-03)

For unassigned claims denied on the basis of failure of the supplier to meet supplier number requirements under §1834(j)(1) of the Act, the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;

- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act;
- Home dialysis supplies and equipment, as described in 1861(s)(2)(F) of the Act;
- Immunosuppressive drugs, as described in 1861(s)(2)(J) of the Act;
- Therapeutic shoes for diabetics, as described in 1861(s)(12) of the Act;
- Oral drugs prescribed for use as an anticancer therapeutic agent, as described in 1861(s)(2)(Q) of the Act;
- Self-administered erythropoietin, as described in 1861(s)(2)(P) of the Act; and
- Such other items as the Secretary may determine.

150.1.4 - Assigned Claims Denied on the Basis of the Prohibition on Unsolicited Telephone Contacts (Rev. 1, 10-01-03)

For assigned claims denied on the basis of the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act; or Medicare payment being denied in advance under §1834(a)(15) of the Act; the term “medical equipment and supplies” means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act; and
- Such other items as the Secretary may determine.

150.1.5 - Assigned Claims Denied on the Basis of Failure of the Supplier to Meet Supplier Number Requirements (Rev. 1, 10-01-03)

For assigned claims denied on the basis of failure of the supplier to meet supplier number

requirements under §1834(j)(1) of the Act, the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act;
- Home dialysis supplies and equipment, as described in 1861(s)(2)(F) of the Act;
- Immunosuppressive drugs, as described in 1861(s)(2)(J) of the Act;
- Therapeutic shoes for diabetics, as described in 1861(s)(12) of the Act;
- Oral drugs prescribed for use as an anticancer therapeutic agent, as described in 1861(s)(2)(Q) of the Act;
- Self-administered erythropoietin, as described in 1861(s)(2)(P) of the Act; and
- Such other items as the Secretary may determine.

150.1.6 - Assigned Claims Denied on the Basis of Not Being Reasonable and Necessary
(Rev. 1, 10-01-03)

For assigned claims denied on the basis of not being reasonable and necessary under §1862(a)(1) of the Act, the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Medical supplies, as described in §1861(m)(5) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act; or
- Such other items as the Secretary may determine.

150.2 - Items and Services Furnished on an Unassigned Basis on or After January 1, 1995
(Rev. 1, 10-01-03)

Nonparticipating suppliers which (1) Do not accept assignment, (2) Do not claim payment after the death of the beneficiary, and (3) Do not bill under the indirect payment procedure, if held to be liable, must refund to beneficiaries any amounts collected for medical equipment and supplies for which Medicare payment is denied for one of the following reasons:

- Under §1834(a)(18)(A) of the Act, the supplier violated the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act; or

- Under §1834(j)(4) of the Act, the supplier did not meet supplier number requirements under §1834(j)(1); or the item is denied in advance under

§1834(a)(15) of the Act; or payment is denied as not reasonable and necessary under §1862(a)(1) of the Act.

In any such payment denial under §1834(a)(17)(B), §1834(j)(1), §1834(a)(15), or §1862(a)(1) of the Act, the beneficiary has no financial responsibility and the refund provisions of §§1834(a)(18), 1834(j)(4) or 1879(h) of the Act, as appropriate, apply, if it is held that the supplier knew or should have known of the likelihood that payment would be denied and that the beneficiary did not know.

For medical equipment and supplies furnished prior to January 1, 1995, Federal law does not limit beneficiaries' liability with respect to unassigned claims for which payment was denied.

150.3 - Items and Services Furnished On an Assigned Basis On or After January 1, 1995
(Rev. 1, 10-01-03)

Under §1879(h) of the Act, suppliers, whether nonparticipating or participating, which accept assignment, if held to be liable, must refund to beneficiaries any amounts collected for medical equipment and supplies for which Medicare payment is denied for one of the following reasons:

- Under §1879(h)(1) of the Act, payment is denied because the supplier did not meet the supplier number requirements under §1834(j)(1) of the Act;

- Under §1879(h)(2) of the Act, payment is denied in advance under §1834(a)(15) of the Act; and

- Under §1879(h)(3) of the Act, payment is denied based on §1834(a)(17)(B) of the Act, the prohibition on unsolicited telephone contacts.

In any such payment denial under §1834(j)(1), §1834(a)(15), or §1834(a)(17)(B) of the Act, the beneficiary has no financial responsibility and the refund provisions apply, if it is held that the supplier knew or should have known of the likelihood that payment would be denied and that the beneficiary did not know. However, in a denial of an assigned claim under §1862(a)(1) of the Act (i.e., payment is denied because the item or service is not reasonable and necessary), the §1879 Limitation on Liability provisions which applied to such denials prior to January 1, 1995, still apply.

150.4 - Time Limits for Making Refunds
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A refund of any amounts collected must be made to the beneficiary on a timely basis. Refund is considered to be on a timely basis only if made within the following time limits:

- If the supplier does not request an appeal of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the supplier receives the remittance advice (RA).

- If the supplier requests an appeal within 30 days of receipt of the notice of the initial determination, the refund must be made to the beneficiary within 15 days after the date the supplier receives the notice of the contractor's determination of the supplier's appeal.

150.5 - Supplier Knowledge Standards for Waiver of Refund Requirement
(Rev. 1, 10-01-03)

A refund is not required of the supplier if the supplier did not know and could not reasonably have been expected to know that Medicare would not pay for the medical equipment or supplies. Following are the knowledge standards applicable to the different types of denials.

150.5.1 - Knowledge Standards for §1862(a)(1) Denials
(Rev. 1, 10-01-03)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay on the basis of medical necessity, apply the same rules that are applicable in determining supplier liability under §1879 of the Act.

150.5.2 - Knowledge Standards for §1834(a)(15) Denials
(Rev. 1, 10-01-03)

150.5.2.1 - Denial of Payment in Advance
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Denial of payment in advance under §1834(a)(15) of the Act refers both to cases in which the supplier requested an advance determination and the contractor determined that the item would not be covered, and to cases in which the supplier failed to request an advance determination when such a request is mandatory.

150.5.2.2 - When a Request for an Advance Determination of Coverage Is Mandatory
(Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

A request for an advance determination of coverage of medical equipment and supplies is mandatory under §1834(a)(15)(C)(i) & (ii) of the Act, respectively, when:

- The item is on the list developed by the Secretary under §1834(a)(15)(A) of items which are frequently subject to unnecessary utilization in your contractor service area; or

- The supplier is on the list developed by the Secretary under §1834(a)(15)(B) of the Act of suppliers for which a substantial number of claims have been denied as not medically reasonable and necessary under §1862(a)(1) of the Act or the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

150.5.2.3 - When a Request for an Advance Determination of Coverage Is Optional
(Rev. 1, 10-01-03)

A request for an advance determination of coverage of medical equipment and supplies is optional under §1834(a)(15)(C)(iii) of the Act when the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests an advance determination.

150.5.2.4 - Presumption for Constructive Notice

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would deny payment in advance under §1834(a)(15) of the Act, presume that the supplier knew that Medicare would not pay in all cases in which the supplier failed to request a mandatory advance determination, on the basis of constructive notice of the lists of items and of suppliers to the supplier through the contractor's regular newsletter/bulletin publication. The supplier would have to submit convincing evidence to the contrary to rebut this presumption.

150.5.2.5 - Presumption When Advance Determination was Requested (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

In determining whether the supplier knew, or could reasonably have been expected to know, before furnishing the item, that Medicare would deny payment in advance under §1834(a)(15) of the Act, presume that the supplier knew that Medicare would not pay in all those cases in which a request for advance determination was made, and the contractor denied payment in advance on the basis that the item is not reasonable and necessary under §1862(a)(1) of the Act or that the item is not covered. This is a nonrebuttable presumption.

150.5.2.6 - Presumption for Listed Overutilized Items (Rev. 1, 10-01-03)

Any denial of a claim for a particular item furnished by a particular supplier because the item is on the §1834(a)(15)(A) list of potentially overutilized items is actual notice to that supplier that an advance determination must be requested for all future claims for that item, and for any other items which are identified in the same notification of denial as being on the list of potentially overutilized items. Presume, on that basis, that that supplier has knowledge that an advance determination must be requested for all future claims for any and all items which are identified in the notification of denial as being on the list of potentially overutilized items. This is a nonrebuttable presumption.

150.5.2.7 - Presumption for Listed Suppliers (Rev. 1, 10-01-03)

Any denial of a claim for an item furnished by a particular supplier because the supplier is on the §1834(a)(15)(B) list of suppliers, is actual notice to that supplier that an advance determination must be requested for all future claims for any item of medical equipment and supplies which that supplier furnishes. Presume, on that basis, that that supplier has knowledge that an advance determination must be requested for all future claims for any and all items of medical equipment and supplies which it furnishes. This is a nonrebuttable presumption.

150.5.2.8 - Presumption for Medical Necessity (Rev. 1, 10-01-03)

In the case of an optional request for an advance determination of coverage of a customized item of medical equipment and supplies under §1834(a)(15)(C)(iii) of the Act by the patient to whom the item is to be furnished or the supplier, in determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would deny payment in advance under §1834(a)(15) of the Act, presume that the supplier knew that Medicare would not pay in all cases in which you denied payment in advance on the basis that the item is not reasonable and necessary under §1862(a)(1) of the Act or that the item is not covered. This is a nonrebuttable presumption.

150.5.2.9 - Presumption About Beneficiary Knowledge (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Presume that a Medicare beneficiary does not know, and cannot reasonably be expected to know, that Medicare will deny, or has denied, payment in advance under §1834(a)(15) of the Act unless and until the beneficiary has received a proper advance beneficiary notice (ABN) to that effect from the supplier before the item is furnished to them.

150.5.3 - Knowledge Standards for §1834(a)(17)(B) Denials (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay because of the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act, presume that the supplier knew that Medicare would not pay on the basis of constructive notice to the supplier through publication of the prohibition on such contacts through the contractor's professional relations function, as well as publicity through trade organizations' own publications, professional training, conventions, etc. The supplier would have to submit convincing evidence to the contrary, showing ignorance of the prohibition on the supplier's part, to rebut this presumption. A single denial of a claim for any item furnished by a particular supplier on the basis of the prohibition on unsolicited telephone contacts shall be held to be actual notice of the prohibition to that supplier; and that supplier shall be considered, on that basis, to have had knowledge that payment would be denied for all such future claims, even those for different items of medical equipment and supplies. That is, after a single denial under §1834(a)(17)(B) of a claim by a particular supplier, the presumption of that supplier's knowledge becomes nonrebuttable.

150.5.4 - Knowledge Standards for §1834(j)(1) Denials (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay due to failure to meet supplier number requirements under §1834(j)(1) of the Act, presume that the supplier knew that Medicare would not pay. Every supplier is expected to know whether or not it has a supplier number, and to know that Medicare will not make payment for medical equipment and supplies furnished a Medicare beneficiary by a supplier which does not have a supplier number. All suppliers should have this knowledge on the basis of the contractor's professional relations function, as well as publicity through trade organizations' own publications, professional training, conventions, etc. The supplier would have to submit extraordinary evidence to the contrary to rebut this presumption. If a supplier submits evidence the contractor finds credible, consult your regional office before rebutting the presumption of supplier knowledge. After a single denial under §1834(j)(1) of a claim by a particular supplier, the presumption of that supplier's knowledge becomes nonrebuttable.

150.5.5 - Additional Knowledge Standards for All Medical Equipment and Supplies Denials

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

The contractor may make a determination, as provided for in Section I.2.D.2.b. imputing a lack of knowledge to a supplier, on the basis that the supplier did not know and could not reasonably have been expected to know that Medicare would not pay, if the supplier did not know and could not reasonably have been expected to know that a purchase (or rental) of medical equipment or supplies involved a Medicare beneficiary.

150.6 - Advance Beneficiary Notice Standards for Waiver of Refund Requirement

(Rev. 1, 10-01-03)

A refund is not required of the supplier if, before the medical equipment or supplies were furnished, the beneficiary was informed by the supplier that Medicare would not pay for the specific item or service and, after receiving such an advance beneficiary notice, the beneficiary agreed to pay for the item or service. This requirement for advance notice may be satisfied by a properly executed Advance Beneficiary Notice (ABN) Form CMS-R-131 used in accordance with the instructions at §50.

150.7 - Appeal Rights

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Nonparticipating suppliers have the same rights to appeal the contractor's determination in an unassigned claim for medical equipment and supplies if the contractor denies payment on the basis of §1862(a)(1) , §1834(a)(17)(B) , §1834(j)(1), or §1834(a)(15) of the

Act as they or participating suppliers have in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the supplier knew or should have known that Medicare would not pay for the item or service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the item or service. In addition to the beneficiary's right to appeal the contractor's decision to deny payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, the beneficiary becomes a party to any appeal request filed by the supplier. Since the beneficiary and the supplier may have adverse interests in a decision regarding refund, it is essential to notify the beneficiary in any case in which the supplier requests an appeal of the denial or asserts that a refund is not required because one of the conditions in §150.5 is met. (See Chapter 29, "Appeals of this Claims Decision," for detailed appeals instructions.)

150.8 - Processing Initial Denials
(Rev. 3560, Issued: 07-15-16, Effective: 10-17-16, Implementation: 10-17-16)

In any unassigned claim for medical equipment and supplies furnished on or after January 1, 1995, in which the contractor denies payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, send separate notices to both the beneficiary (a Medicare Summary Notice (MSN)) and the supplier (a remittance advice (RA)).

Note: This instruction to send a remittance advice to the supplier in the case of denial of an unassigned claim is a specific requirement of §1834(a)(18)(C) of the Act, incorporated by reference into §1834(j)(4) and §1879(h) of the Act, applicable to denials of claims for medical equipment and supplies furnished on or after January 1, 1995.

If the beneficiary signed an ABN which satisfies the requirements in subsection II.6 and the supplier included a GA modifier on the claim to that effect, do not make an automatic finding that the claim should be denied on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, merely because the supplier submitted a GA modifier. The fact that an ABN was given to the beneficiary will in no way prejudice the contractor's determination as to whether there is or is not sufficient evidence to justify a denial. In the case where there is an ABN, mail a standard denial MSN notice to the beneficiary. If the beneficiary did not sign an ABN and the supplier included a GZ modifier on the claim to that effect, include, in addition to one of the denial notices in Chapter 21, "Medicare Summary Notices," the following initial beneficiary notice in the MSN sent to the beneficiary.

A. Initial Beneficiary Notice

(MSN 8.54)

If the supplier knew that Medicare wouldn't pay and you paid, you might get a refund unless you signed a notice in advance. Refunds may be delayed if the provider appeals. Call your supplier if you don't hear anything within 30 days.

(MSN 8.54) - In Spanish

Si pagó por un servicio que su proveedor sabía Medicare no iba a pagar, usted tiene derecho a un reembolso, a menos de que haya firmado un aviso por adelantado. Los reembolsos se pueden demorar si el proveedor apela la decisión. Llame a su proveedor si no escucha nada en 30 días.

B. Initial Supplier Notice

Include in the notice to the supplier the following;

- The patient's name and health insurance claim number;
- A description of the item or service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN, (see Chapter 21, "Medicare Summary Notices"); and

- If the supplier submitted a GA modifier (signed ABN obtained), include in the notice to the supplier the following Notice 1. However, if the supplier submitted a "-GZ" modifier (a signed ABN was not obtained), include in the notice to the supplier the following Notice 2.

Notice 1. – Signed Advance Beneficiary Notice Obtained

(Remittance Advice Remark Code N124)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.

Remittance Advice Remark Codes cannot be reported without a Claim Adjustment Reason Code and a Group Code. For Notice 1 where ABN has been obtained, use CARC 96 - Non-covered charge(s), and Group Code – PR (Patient Responsibility).
Or

Notice 2. – Signed Advance Beneficiary Notice Not Obtained

(Remittance Advice Remark Code N125)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: if you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or if you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.

Remittance Advice Remark Codes cannot be reported without a Claim Adjustment Reason Code and a Group Code. For Notice 2 where ABN has NOT been obtained, use CARC 96 - Non-covered charge(s), and Group Code – CO (Contractual obligation).

If an exception applies to you, or you believe the contractor was wrong in denying payment, you should request an appeal of this determination by the contractor

within 30 days of receiving this notice. Your request for appeal should include any additional information necessary to support your position. If you request an appeal within 30-days, you may delay refunding to the beneficiary until you receive the results of the appeal. If the appeal determination is favorable to you, you do not have to make any refund. If the appeal is unfavorable, you must make the refund within 15 days of receiving the unfavorable appeal decision.

You may request an appeal of the determination at any time within 120 days of receiving this notice. An appeal requested after the 30-day period does not permit you to delay making the refund. Regardless of when an appeal is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1834(a)(18) of the Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact (contractor contact, telephone number).

Ensure that the telephone number puts the supplier in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

Note: These procedures do not apply where the contractor automatically denies Part B services related to hospital inpatient services denied by the Quality Improvement Organization (QIO). In those cases, the QIO is responsible for notifying the beneficiary and supplier of the refund requirements of §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act and making the refund determination where appropriate.

150.9 - Processing Beneficiary Requests for Appeal (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a beneficiary requests an appeal of the initial denial, process the appeal in the normal fashion except that, where the appeal results in a reversal, include the following special paragraph in the appeal notice sent to the beneficiary:

The supplier which furnished this item or service has been informed of this decision and advised that it may collect its full charge for the item or service.

Send the supplier which furnished the item or service a separate notice which clearly identifies the item or service for which payment is being made (i.e., include the patient's name, health insurance claim number, a description of the item or service billed by procedure code, date and place of service, and amount of the charge. Include the following language:

You were previously advised that Medicare payment could not be made for this item or service. However, after reviewing this claim, we have determined that payment may be made. Therefore, if you have already refunded the amounts you collected from the beneficiary for this item or service, you may recollect these amounts.

150.10 - Processing Supplier Requests for Appeal (Rev. 1186, Issued: 02-23-07; Effective: 01-01-06; Implementation: 05-23-07)

Where a supplier requests an appeal, notify the beneficiary as discussed in §150.7 . The appeal process consists of three stages, even though the supplier may be contesting only one issue (e.g., the supplier may assert that it did not know, and could not have reasonably have been expected to know, that Medicare would not pay for the items or services).

150.10.1 - Appeal of the Denial of Payment (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

The first stage of the appeal is a new, independent, and critical reexamination of the facts regarding the denial of payment. If the contractor finds that the initial denial of payment was appropriate, go on to §150.10.2.

150.10.2 - Beneficiary Given Advance Beneficiary Notice and Agreed to Pay (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

A supplier which has given the beneficiary an ABN and has obtained the beneficiary's signed statement agreeing to pay, is not required to make a refund. If the supplier claims to have given an ABN to the beneficiary, the contractor will ask the supplier to furnish a copy of the ABN. Examine the ABN to determine whether it meets the standards in §40.3 and §50. In the absence of acceptable evidence of advance beneficiary notice, go on to §150.10.3.

150.10.3 - Supplier Knowledge
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

A supplier which did not know and could not reasonably have been expected to know that Medicare would not pay for the medical equipment or supplies is not required to make a refund. If the supplier claims not to have had any such knowledge, the contractor will determine whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay by applying the knowledge standards provided in §150.5.

Guide Paragraphs for Inclusion in Appeal Determination
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Upon completion of the appeal, the contractor will send the supplier an appeal notice. Send a copy to the beneficiary. If the initial payment determination is reversed to payment, include in the appeal notice the supplier notice language required in §150.9. Otherwise, include one of the following paragraphs concerning refund.

Paragraph 1. Refund Not Required - Beneficiary Was Given Advance Beneficiary Notice and Agreed to Pay

Under §1834(a)(18) and under §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not required if, prior to furnishing the items or services, the supplier notified the beneficiary in writing that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that you informed the beneficiary in advance that Medicare does not pay for the above items or services and the beneficiary agreed to pay for them. Therefore, you are not required to make a refund in this case. The beneficiary has been sent a copy of this notice.

Paragraph 2. Refund Not Required - Supplier Did Not Know That Medicare Would Not Pay For the Services

Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not necessary if the supplier did not know,

and could not reasonably have been expected to know, that Medicare does not pay for the items or services. After reviewing this claim, we find that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the above items or services. Therefore, you are not required to make a refund in this case. Upon your receipt of this notice, it is considered that you now have knowledge of the fact that Medicare does not pay for (description of item or service) similar conditions. The beneficiary has been sent a copy of this notice.

Paragraph 3. Adverse Action on Denial - Refund Required

Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1),
§1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. A refund is not required if (1) The supplier did not know, and could not reasonably have been expected to know, that Medicare would not pay for the items or services; or (2) The supplier notified the beneficiary in writing before furnishing the items or services that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that neither of these conditions is met in this case.
You must therefore refund any amount you collected for these items or services within 15 days from the date you receive this notice. A refund must be made within 15 days from receipt of this notice for you to be in compliance with the law. The beneficiary has been sent a copy of this notice.

Suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties (up to $10,000 per item or service), assessments (three times the amount of the claim), and exclusion from the Medicare program.

Note: For claims presented to the contractor prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

150.11 - Supplier Fails to Make Refund
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Under §1834(a)(18)(B) of the Act, a supplier which knowingly and willfully fails to make refund within the time limits in §150.4 may be subject to sanctions under §1128A the Act (i.e., civil money penalties (up to $10,000 per item or service), assessments (three times

the amount of the claim), and exclusion from the Medicare program).

Note: For claims presented to the contractor prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

Generally, the failure of a supplier to make a refund to a beneficiary comes to the contractor's attention as a result of a beneficiary complaint or a referral from the Social Security Administration (SSA) or the CMS. Document beneficiary complaints and, if necessary, contact the beneficiary to clarify the information in the complaint and determine the amount the beneficiary paid the supplier for the denied items or services. If the contractor determines that a supplier failed to make a refund, the contractor will contact the supplier in person or by telephone (if that is not feasible, contact the supplier by letter) to discuss the facts of the case. The contractor will attempt to determine why the amounts collected have not been refunded. Explain that the law requires that the supplier make a refund to the beneficiary and that if it fails to do so, the Secretary may impose civil money penalties, assessments, and exclusion from the Medicare program. Make a dated report of contact. Include the information relayed to the supplier and the supplier's response. Re-contact the beneficiary in 15 days to determine whether the refund has been made. Do not make any referral to the CMS regional office until the supplier has been formally notified to refund the money and the supplier's appeal rights have been exhausted, or until the time limit for an appeal has passed.

150.12 - CMS Regional Office (RO) Referral Procedures (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Prior to submitting any materials to the RO, the contractor will contact the RO to determine how to proceed in referring a potential sanction case. When referring a sanction case to the region, include in the sanction recommendation (to the extent appropriate) the following:

Background of the Subject

The subject's business name, address, Medicare Identification Number, owner's full name and Social Security Number, Tax Identification Number (if different), and a brief description of the subject's special field of medical equipment and supplies business.

Origin of the Case

A brief description of how the violations were discovered.

Statement of Facts

A statement of facts in chronological order describing each failure to comply with the refund requirements.

Documentation

Include copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiaries and the supplier regarding the supplier's failure to make refunds. Include a listing of the following for each item or service not refunded to the beneficiary by the supplier (grouped by beneficiary):

- Beneficiary Name and Health Insurance Claim Number;
- Claim Control Number;
- Procedure Code (CPT-4 or HCPCS) of nonrefunded item or service;
- Procedure Code modifier;
- Date of Service;
- Place of Service Code;
- Submitted Charge;
- Units (quantity) of Item or Service; and
- Amount Requested to be Refunded.

Other Significant Issues

Include any information that may be of value to the RO while they review and possibly develop a case to impose sanctions.

150.13 - Imposition of Sanctions (Rev. 1, 10-01-03)

Section 1834(a)(18)(B) of the Act provides that if a supplier knowingly and willfully fails to make required refunds, the Secretary may impose the sanctions provided in §1842(j)(2) of the Act in the same manner as such sanctions are authorized under §1128A of the Act. These include civil money penalties, assessments, and exclusion from the Medicare program for a period of up to five years. The CMS RO will make the determination on whether to proceed in developing a monetary penalty or program exclusion case based upon a failure to make refunds.

150.14 - Supplier's Right to Recover Resaleable Items for Which Refund Has Been Made
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

If the contractor denies Part B payment for an item of medical equipment or supplies on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, and the beneficiary is relieved of liability for payment for that item under §1834(a)(18) of the Act, the effect of the denial, subject to State law, cancels the contract for the sale or rental of the item and, if the item is resaleable or re-rentable, permits the supplier to repossess that item for resale or re-rental. In the case of consumable items or any other items which are not fit for resale or re-rental and which cannot be made fit for resale or re-rental, suppliers are strongly discouraged from recovering these items since such actions reasonably could be viewed as purely punitive in nature. If a supplier makes proper refund under §1834(a)(18) of the Act, Medicare rules do not prohibit the supplier from recovering from the beneficiary items which are resalable or re-rentable.

Alternatively, when the contract of sale or rental is cancelled on the basis described above, whether or not the supplier physically repossesses the resaleable or re-rentable item, the supplier may enter into a new sale or rental transaction with the beneficiary with respect to that item as long as the beneficiary has been informed of their liability. If the circumstances which preclude payment for the item have been removed, e.g., the supplier has now obtained a supplier number, the supplier may submit to the contractor a new Part B claim based on the resale or re-rental of the item to the beneficiary. If Part B payment is still precluded, the supplier can establish the beneficiary's liability for payment for the denied resold or re-rented item by giving the beneficiary an ABN notifying the beneficiary of the likelihood that Medicare will not pay for the item and obtaining the beneficiary's signed agreement to pay for the item. The resale or re-rental of the item to the beneficiary does not change the fact that the beneficiary is relieved of liability in connection with the original transaction.

Under the capped-rental method, if the contractor determines that the supplier is obligated to make a refund, the supplier must repay Medicare those rental payments that the supplier has received for the item. However, the Medicare beneficiary must return the item to the supplier.

200 - Expedited Review Process for Hospital Inpatients in Original Medicare
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to a QIO for an expedited review when a hospital, with physician concurrence, determines that

inpatient care is no longer necessary. The instructions that follow stem directly from regulations at 42 CFR 405.1205 and 405.1206 and are effective July 1, 2007. These regulations are also referenced at 42 CFR 489.27 and 412.42 (c)(3). The authority for these instructions stems from Sections 1866(a)(1)(M), 1869(c)(3)(C)(iii)(III), and 1154(e) of the Social Security Act. Instructions for managed care will be located in Chapter 13 of the Medicare Managed Care Manual.

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

For those beneficiaries who request a QIO review, hospitals must deliver a Detailed Notice of Discharge as soon as possible, but no later than noon of the day after the QIO's notification. Both the IM and the Detailed Notice must be the standardized notices provided by CMS.

200.1 - Scope of the Instructions
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

These instructions implement 42 CFR 405.1205 and 405.1206 which require hospitals to inform Medicare beneficiaries who are hospital inpatients of their right to a QIO review. These instructions delineate the expectations of beneficiaries (or their representative, if applicable), responsibilities of hospitals, and the role of the QIOs when the beneficiary requests an expedited review by a QIO of the discharge decision. For purposes of this instruction, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

Hospitals Affected by these Instructions. The term hospital is defined in the regulation as any facility providing care at the inpatient hospital level, whether that care is short term or long term, acute or non acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals. This means all hospitals paid under the Inpatient Acute Prospective Payment System (IPPS), sole community hospitals/regional referrals centers or any other type of hospital receiving special consideration under IPPS (for example, Medicare dependent hospitals, Indian Health Service hospitals); hospitals not under IPPS, including, but not limited to: hospitals paid under State or United States territory waiver programs, hospitals paid under certain

demonstration projects cited in regulation (§489.34), rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, critical access hospitals, children's hospitals, and cancer hospitals. Swing beds in hospitals are excluded, because they are considered a lower level of care. Religious nonmedical health care institutions are also excluded.

Hospital Inpatients who are Medicare Beneficiaries. These instructions apply to beneficiaries in original Medicare who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as those in observation stays or in the emergency department, do not receive these notices, unless they subsequently require inpatient care. Medicare beneficiaries in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care.

Definition of Discharge. The term "discharge" is defined as a formal release of a beneficiary from an inpatient hospital. This includes when the beneficiary is physically discharged from the hospital as well as when the beneficiary is discharged "on paper" – meaning that the beneficiary remains in the hospital, but at a lower level of care (for example, the beneficiary is moved to a swing bed or to custodial care).

200.2 - Special Considerations
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Other Insurers. Section 1866(a)(1)(M), delivery of the Important Message from Medicare, applies to each individual who is entitled to benefits under Medicare Part A. Therefore, these requirements apply if a beneficiary is eligible for both Original Medicare and Medicaid (a dual eligible), is eligible for Original Medicare and another insurance program or payer, or has Medicare as a secondary payer. No matter where in the sequence of payers Medicare falls, these requirements still apply.

Inpatient to Inpatient Transfers. Beneficiaries who are being transferred from one inpatient hospital setting to another inpatient hospital setting, do not need to be provided with the follow-up copy of the notice prior to leaving the original hospital, since this is considered to be the same level of care. Beneficiaries always have the right to refuse care and may contact the QIO if they have a quality of care issue. The receiving hospital must deliver the Important Message from Medicare again according to the procedures in these instructions.

Preadmission/Admissions for Services that are Not Reasonable and Necessary. When a Medicare beneficiary is planning to be hospitalized for services that Medicare usually pays for, but are not considered to be reasonable and necessary in this particular situation, hospitals must deliver a Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN). (See Section 240 of this Chapter.) The Important Message from Medicare would be delivered only if the stay became a covered stay.

Admissions for Services that Medicare Never Covers. When a Medicare beneficiary is admitted for hospital services that are never covered by Medicare, hospitals may deliver the Preadmission/Admission HINN. The IM would be delivered only if the stay became a covered stay.

Change of Status from Inpatient to Outpatient. When a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient. See CR 3444 (Use of Condition Code 44) and MedLearn Matters article, SE0622, published on March 22, 2006, for notification requirements in this situation.

End of Part A days. For purposes of this instruction, the term discharge does not include exhaustion of Part A days, therefore, when a beneficiary exhausts Part A days, these requirements do not apply.

Hospital Requests QIO Review when the Physician does not Concur. There are separate existing requirements under 405.1208 for notifying a beneficiary when the hospital requests a QIO review. Hospitals should deliver the Notice of a Hospital Requested Review (HRR). (See Section 220 of this chapter.)

200.3 - Notifying Beneficiaries of their Right to an Expedited Review (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily-required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

200.3.1 - Delivery of the Important Message from Medicare (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals must follow the procedures listed below in delivering the Important Message from Medicare (IM). Valid Notice consists of:

Use of Standardized Notice. Hospitals must use the standardized form (CMS-R-193), see Section 200.6.2. The notices are also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the

form except where indicated (see Section 200.6 on Completing the Notice). The OMB control number must be displayed on the notice.

Delivery Timeframe. Hospitals must deliver the original copy of the IM at or near admission, but no later than 2 calendar days following the date of the beneficiary's admission to the hospital.

Hospitals may deliver the initial copy of the notice if the beneficiary is seen during a preadmission visit, but not more than 7 calendar days in advance of admission. If a beneficiary receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered if delivery of the initial copy occurred more than 2 calendar days prior.

In-Person Delivery. The IM must be delivered to the beneficiary in person. However, if the beneficiary is not able to comprehend the notice, it must be delivered to and signed by the beneficiary's representative.

Notice Delivery to Representatives. CMS requires that notification of a beneficiary who is not competent be made to a representative of the beneficiary. A representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed "durable medical power of attorney").

Otherwise, a person (typically, a family member or close friend) whom the beneficiary has indicated may act for him or her, but who has not been named in any legally binding document may be a representative for purpose of receiving the notices described in this section. Such representatives should have the beneficiary's best interests at heart and must act in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary. A notifier (including the notifier's employees) that has a conflicting interest (such as shifting financial liability to the beneficiary) is not qualified to be a representative. (Note: If the beneficiary wishes to appoint a representative to file an appeal on his/her behalf, a valid Form 1696 or a conforming written instrument must be signed by both the beneficiary and the prospective representative and filed with the appeal request. See Medicare Claims Processing Manual, Publication 100-4, Ch. 29, Section 270 for specific instructions related to the use of Form 1696 and the appointment of representatives).

Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Hospitals are required to develop procedures to use when the beneficiary is incapable of receiving or incompetent to receive the notice, and the hospital cannot obtain the signature of the

beneficiary's representative through direct personal contact.

Regardless of the competency of a beneficiary, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him or her of the beneficiary's rights as a hospital patient, including the right to appeal a discharge decision.

The information provided should include the following at a minimum:

- The name and telephone number of a contact at the hospital;
- The beneficiary's planned discharge date, and the date when the beneficiary's liability begins;
- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision;
- How to get a copy of a detailed notice describing why the hospital and physician believe the beneficiary is ready to be discharged;
- A description of the steps for filing an appeal;
- When (by what time/date) the appeal must be filed to take advantage of the liability protections;
- The entity required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires in order to receive the appeal in a timely fashion;
- Direction to the 1-800-MEDICARE number for additional assistance to the representative in further explaining and filing the appeal; and

The date the hospital conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. Place a dated copy of the notice in the beneficiary's medical file, and document the telephone contact with the beneficiary's representative (as listed above) on either the notice itself, or in a separate entry in the beneficiary's file or attachment to the notice. The documentation should indicate that the staff person told the representative the planned discharge date, the date the beneficiary's financial liability begins, the beneficiary's appeal rights, and how and when to initiate an appeal. The documentation should also include the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested, or other delivery method that requires signed verification of delivery. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date received. Place a copy of the notice in the beneficiary's medical file, and document the attempted telephone contact to the members' representative. The documentation should include: the name of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called.

If both the hospital and the representative agree, hospitals may send the notice by fax or email, however, hospitals must meet the HIPAA privacy and security requirements.

Ensuring Beneficiary Comprehension. Hospitals must make every effort to ensure the beneficiary comprehends the contents of the notice before obtaining the beneficiary's signature. This includes explaining the notice to the beneficiary if necessary and providing an opportunity for the beneficiary to ask questions. The hospital should answer all the beneficiary's questions orally to the best of its ability. The beneficiary should be able to understand that he or she may appeal a discharge decision without financial risk, but may have to pay for any services received after the discharge date if he or she stays in the hospital and does not appeal. Notices should not be delivered during an emergency, but should be delivered once the beneficiary is stable.

These instructions do not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if a beneficiary is able to comprehend the notice, but either is physically unable to sign it or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting use of such assistance.

Beneficiary Signature and Date. The IM must be signed and dated by the beneficiary to indicate that he or she has received the notice and can comprehend its contents, unless an appropriate reason for the lack of signature is recorded on the IM, such as a properly annotated signature refusal (see below).

Refusal to Sign and Annotation. If a beneficiary refuses to sign the notice, hospitals may annotate the notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice. The annotation may be placed in the unused patient signature line, in the "Additional Information" section on page 2 of the notice or another sheet of paper may be attached to the notice, if necessary. Any insertions on the notice must be easy for the beneficiary to read in order for the notice to be considered valid. See also Section 200.5.6 - Insertions in Blanks.

Notice Delivery and Retention. Hospitals must give the original copy of the signed or annotated notice to the patient. Hospitals must retain a copy of the signed notice and may determine the method of storage that works within their existing processes, for example, storing a copy in the medical record or electronically.

200.3.2 - The Follow-Up Copy of the Signed Important Message from Medicare
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A "follow-up" copy of the signed IM must be delivered to the beneficiary using the following guidelines:

Delivery Timeframe. The follow-up copy must be delivered as far in advance of discharge as possible, but no more than 2 calendar days before the planned date of discharge. Thus, when discharge seems likely within 1- 2 calendar days, hospitals should make arrangements to deliver the follow-up copy of the notice, so that the beneficiary has a meaningful opportunity to act on it. However, when discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge, if necessary. If the follow-up copy of the notice must be delivered on the day of discharge, hospitals must give beneficiaries who need it at least 4 hours to consider their right to request a QIO review. Beneficiaries may choose to leave prior to that time, however, hospitals must not pressure a beneficiary to leave during that time period. If the hospital delivers the follow-up copy, and the beneficiary status subsequently changes, so that the discharge is beyond the 2-day timeframe, hospitals must deliver another copy of the signed notice again within 2 calendar days of the new planned discharge date. Hospitals may not develop procedures for delivery of the follow up copy routinely on the day of discharge.

Alternative to Delivery of the Signed Copy. A hospital may choose to deliver a new copy of the IM (not a copy of the signed IM) during the required timeframes; however, the hospital must obtain the beneficiary's or representative's signature and date on the notice again at that time.

Exception to Delivery of the Follow-Up Copy. If delivery of the original IM is within 2 calendar days of the date of discharge, no follow-up notice is required. For example, if a beneficiary is admitted on Monday, the IM is delivered on Wednesday and the beneficiary is discharged on Friday, no follow-up notice is required.

If a beneficiary receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered if delivery of the initial copy occurred more than 2 calendar days prior.

Documentation. Hospitals must document timely delivery of the follow-up copy of the IM in the patient records, when applicable. Hospitals are responsible for demonstrating compliance with this requirement. If hospitals have processes in place to document delivery of other information related to discharge that includes a beneficiary signature and date, hospitals may include the follow-up copy of the notice in those documents. If there are no other existing processes in place, hospitals may use the "Additional Information" section of the IM to document delivery of the follow-up copy, for example, by adding a line for the beneficiary's or representative's initials and date.

200.4 - Rules and Responsibilities when a Beneficiary Requests an Expedited Review

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A beneficiary has a right to request an expedited review by the QIO when a hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary.

200.4.1 - The Role of the Beneficiary and Liability (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Submitting a Request: A beneficiary who chooses to exercise the right to an expedited review must submit a request to the QIO that has an agreement with the hospital where the beneficiary is an inpatient. In order to be considered timely, the request must be made no later than midnight of the day of discharge, may be in writing or by telephone, and must be before the beneficiary leaves the hospital. The beneficiary, upon request of the QIO, should be available to discuss the case. The beneficiary may, but is not required to, submit written evidence to be considered by the QIO.

Timely Requests: When the beneficiary makes a timely request for a QIO review – that is, requests a review no later than midnight of the day of discharge – the beneficiary is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the beneficiary receives notification of the expedited determination from the QIO. Liability for further inpatient hospital services depends on the QIO decision:

- **Unfavorable determination**: If the QIO notifies the beneficiary that the QIO did not agree with the beneficiary, liability for continued services begins at noon of the day after the QIO notifies the beneficiary that the QIO agreed with the hospital's discharge determination, or as otherwise determined by the QIO.

- **Favorable determination**: If the QIO notifies the beneficiary that the QIO agreed with the beneficiary, the beneficiary is not financially responsible for continued care (other than applicable coinsurance and deductibles) until the hospital once again determines that the beneficiary no longer requires inpatient care, secures the concurrence of the physician responsible for the beneficiary's care or the QIO, and notifies the beneficiary with a follow-up copy of the IM.

Untimely Requests: When the beneficiary fails to make a timely request for an expedited review, and remains in the hospital, he or she still may request an expedited review at any time, but the beneficiary may be held responsible for charges incurred after the day of discharge, or as otherwise stated by the QIO. If the QIO finds that the patient should have remained an inpatient, the hospital will refund the beneficiary any funds that were collected. When the beneficiary fails to make a timely request for an expedited

review and is no longer an inpatient at the hospital, he or she may still request a QIO review within 30 calendar days of the date of discharge, or at any time for good cause.

200.4.2 - The Responsibilities of the Hospital (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Provide the Detailed Notice of Discharge: When a QIO notifies the hospital that a beneficiary has requested an expedited review, the hospital must deliver a Detailed Notice of Discharge (the Detailed Notice) to the beneficiary as soon as possible but not later than noon of the day after the QIO's notification. If a beneficiary requests more detailed information prior to requesting a review, hospitals may deliver the detailed notice in advance of the beneficiary requesting a review.

Use of Standardized Notice. Hospitals must use the standardized form (CMS-10066), see Section 200.6.2. This notice is also available on www.cms.hhs.gov/bni at the Link for Hospital Discharge Appeal Notices. Hospitals may not deviate from the content of the form except where indicated (see Section 200.6.2 on Completing the Notice). The OMB control number must be displayed on the notice.

The Detailed Notice must be the standardized notice provided by CMS and contain the following:

- A detailed explanation why services are either no longer reasonable and necessary or are otherwise no longer covered.
- A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including information about how the beneficiary may obtain a copy of the Medicare policy. (See instructions for the Detailed Notice of Discharge at Section 200.6.3, Exhibit 2)
- Facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case.
- Any other information required by CMS.

Hospitals must follow requirements in Section 200.5.6 on Insertions in Blanks and Section 200.6. on Completing the Notices.

Provide Information to the QIO. Upon notification by the QIO of the beneficiary's request for an expedited review, the hospital must supply any and all information that the QIO needs to make the expedited determination, including copies of both the IM and the

Detailed Notices. The hospital must furnish this information as soon as possible, but no later than noon of the day after the QIO notifies the hospital of the request. At the discretion of the QIO, the hospital may make the information available by telephone or in writing. A written record of any information not transmitted in writing should be sent as soon as possible. If the hospital fails to provide the needed information, the QIO may make a decision based on evidence at hand or defer the decision until it receives the necessary information. If this delay results in extended coverage of an individual's hospital services, the hospital may be held financially liable for those services, as determined by the QIO.

Burden of Proof. The burden of proof lies with the hospital to demonstrate that discharge is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies.

Provide the Beneficiary with Documentation if Requested. At the request of the beneficiary, the hospital must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIO, including written records of any information provided by telephone. The hospital may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The hospital must accommodate the request by no later than the first day after the material is requested.

200.4.3 - The Role of the QIOs

QIO Availability. The QIO should have methods in place to accept requests for reviews outside of normal business hours, such as an answering machine message. QIOs will issue decisions within one calendar day after it receives all pertinent information.

Notify the hospital of the beneficiary's request for an expedited review. When the QIO receives the request from the beneficiary, the QIO must notify the hospital of the request immediately, or immediately in the morning if the request is received after the QIO's business hours.

Receive and Examine records. The QIO will examine medical and other records that pertain to the services in dispute.

Determine if the hospital delivered valid notice. The QIO will determine whether the hospital delivered valid notice, meaning that the notice is the standardized notice published by CMS, meets the notice delivery timeframes, and has been signed and dated by the beneficiary. If the QIO determines that the hospital did not deliver valid notice, the QIO will instruct the hospital to reissue the notice if necessary, proceed with the review, and educate the hospital retrospectively. If the beneficiary or representative makes an untimely request for a review, and the QIO determines that the beneficiary did not

receive valid notice, the QIO will determine the date the beneficiary becomes fully liable for the services.

Solicit the views of the beneficiary. The QIO must solicit views of the beneficiary who requested the expedited review.

Solicit the views of the hospital. The QIO must provide an opportunity for the hospital to explain why the hospital and physician believe discharge is appropriate. The QIO may develop guidelines as to the form and extent of this opportunity.

If needed information is not received. If the QIO does not receive the information from the hospital needed to sustain the discharge decision, it may make its determination based on the evidence at hand or it may defer a decision until it receives the necessary information. If this delay results in extended Medicare coverage of an individual's hospital services, the hospital may be held financially responsible for these services as determined by the QIO.

QIO Determination. QIOs make their determinations based on criteria in §1154(a) of the Act, which specifies that QIOs will determine whether:

- the services are reasonable and medically necessary,
- the services meet professionally recognized standards of care, and
- the services could be safely be delivered in another setting.

Notification following a timely request. When the beneficiary makes a timely request for an expedited review, the QIO must make its determination and notify the beneficiary, the hospital, and the physician of its determination within one calendar day after it receives all requested pertinent information. When the QIO issues an expedited determination, the QIO must notify the beneficiary, the hospital and the physician of its decision by telephone, followed by a written notice that must include the following information:

- The basis for the determination.
- A detailed rationale for the determination.
- An explanation of the Medicare payment consequences of the determination and the date a beneficiary becomes fully liable for services.
- Information about the beneficiary's right to an reconsideration of the QIO's determination, including how to request the reconsideration

and the timeframe for doing so.

Notification following an untimely request. When the beneficiary makes an untimely request for an expedited review, and remains in the hospital, the QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 2 calendar days after it receives all requested pertinent information. When the beneficiary makes an untimely request for an expedited review, and is no longer an inpatient in the hospital, the QIO will make its determination and notify the beneficiary, the hospital, and the physician of its determination within 30 calendar days after it receives all requested pertinent information.

200.4.4 - Effect of a QIO Expedited Determination (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The QIO determination is binding on the beneficiary, the physician, and hospital except in the following circumstances:

Right to pursue a reconsideration. If the beneficiary is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures described in 405.1204.

Right to pursue the general claims appeal process. If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, the determination is subject to the general claims appeal process (See Chapter 29 of this manual.).

200.5 - General Notice Requirements (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Since the Important Message from Medicare and the Detailed Notice of Discharge are OMB approved, standardized notices, hospitals must comply with the following General Notice Requirements:

200.5.1 - Number of Copies (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The Important Message from Medicare: In most cases, a minimum of three copies of the Important Message from Medicare, including the original, will be needed. The beneficiary keeps the original signed notice and will receive a follow-up copy of the signed notice, except when delivery of the original notice falls within two days of discharge. The hospital must retain a copy of the signed IM and may do so electronically.

The Detailed Notice: A minimum of two copies of the Detailed Notice, including the original, will be needed. The beneficiary keeps the original notice. The hospital must retain a copy of the signed document and may do so electronically.

Providing Copies to the QIO: In addition to the above, if a beneficiary requests a review, hospitals are required to provide copies of both notice described in this section to the QIO.

200.5.2 - Reproduction
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals may reproduce the notices by using self-carbonizing paper, photocopying the IM, or using another appropriate method. All reproductions must conform to applicable instructions.

200.5.3 - Length and Page Size
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

The Important Message from Medicare: The IM must NOT exceed two sides of a page in length. The IM is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information hospitals insert in the notice.

The Detailed Notice: The Detailed Notice must NOT exceed one side of a page in length. The Detailed Notice is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information hospitals may insert in the notice. Hospitals may attach applicable Medicare policies to the notice.

200.5.4 - Contrast of Paper and Print
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (e.g., white on black), or block-shade (highlight) notice text.

200.5.5 - Modification
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The notices described in this section may not be modified, except as specifically allowed by these instructions. In no case may either notice be condensed.

200.5.6 - Font
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The IM and the Detailed Notice must meet the following font requirements in order to facilitate beneficiary understanding:

- **Font Type:** To the greatest extent practicable, the fonts as they appear in the notices on the CMS Web site should be used. Any changes in the font type should be based solely on software and/or hardware limitations of the notices. Examples of easily readable alternative fonts include: Arial, Arial Narrow, Times New Roman, and Courier.

- **Font Effect/Style:** Any changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the notices more difficult to read.

- **Font Size:** The font size generally should be 12 point. Titles should be 18 point, but handwritten insertions in blanks of the IM can be as small as 10 point if needed.

- **Insertions in Blanks:** Information inserted by hospitals in the blank spaces on the IM and the Detailed Notice may be typed or legibly hand-written using the guidelines above.

200.5.7 - Customization
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals are permitted to do some customization of IM or the Detailed Notice such as pre-printing agency-related information to promote efficiency and to ensure clarity for beneficiaries. Guidelines for customization are:

- Maintaining underlines in the blank spaces is not required.

- Information in blanks that is constant can be pre-printed, such as the hospital's name, QIO name and telephone number. Note the TTY phone number also needs to be entered.

200.5.8 - Retention of the Notices
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospitals are required to retain copies of the signed notices and may do so either in hardcopy or electronically.

200.6 - Completing the Notices
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When completing the Important Message from Medicare and the Detailed Notice of

Discharge, hospitals must utilize the following instructions:

200.6.1 - Translated Notices
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Both the "Important Message from Medicare" and the "Detailed Notice of Discharge" are available at http://www.cms.hhs.gov/BNI/. The notices will be available in English and Spanish, and in PDF and Word formats, under a dedicated link on the left hand margin: "Hospital Discharge Appeal Notices". Hospitals should choose the appropriate version of the Important Message from Medicare and the Detailed Notice of Discharge based on the language the beneficiary best understands. When Spanish-language notices are used, the hospital should make insertions on the notice in Spanish. If this is impossible, additional steps need to be taken to ensure that the beneficiary comprehends the content of the notice.

200.6.2 - Exhibit 1 - Important Message from Medicare (CMS-R-193) and Form Instructions
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Patient Name:
Patient ID Number:
Physician:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

An Important Message From Medicare

About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

- Be involved in any decisions about your hospital stay, and know who will pay for it.

- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here {Insert Name and Telephone Number of the QIO} _.

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.

- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

    - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**

    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call

.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative Date

CMS-R-193 (approved 05/2007)

Steps To Appeal Your Discharge

- Step 1: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
    - Here is the contact information for the QIO:

      {insert name of QIO in bold}
      {insert telephone number of QIO}

    - You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
    - Ask the hospital if you need help contacting the QIO.
    - The name of this hospital is {insert the name of the hospital and the provider ID number} .
- Step 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- Step 3: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- Step 4: The QIO will review your medical records and other important information about your case.
- Step 5: The QIO will notify you of its decision within 1 day after it receives all necessary information.
    - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
    - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
    - If you have Original Medicare: Call the QIO listed above.
    - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877- 486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice Instructions

The Important Message from Medicare (OMB #0938-0692) (CMS-R-193)

Completing the Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display "DEPARTMENT OF HEALTH & HUMAN SERVICES,
Centers for Medicare & Medicaid Services" and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

Physician: Fill in the name of the patient's physician.

B. Body of the Notice

Bullet # 3 Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here .
Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date: Have the patient or representative place the date he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet - Insert name and telephone number of QIO in BOLD: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials to document delivery of the follow- up copy of the IM, or documentation of refusals.

200.6.3 - Exhibit 2 – The Detailed Notice of Discharge (CMS 10066) and Form Instructions

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Patient Name: OMB Approval No. 0938-1019

Patient ID Number: Date Issued:

Physician:

{Insert Hospital or Plan Logo here}

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on . This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

Medicare Managed Care policies, if applicable: (insert specific managed care policies)

Other {insert other applicable policies}

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call {insert hospital and/or plan telephone number}.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
CMS 10066 (approved 5/2007)

Instructions for Completing the Detailed Notice of Discharge (CMS 10066)

This is a standardized notice. Hospitals may not deviate from the content of the form except where indicated. Please note that the OMB control number must be displayed on the notice. Insertions must be typed or legibly hand-written in 12-point font or the equivalent.

Hospitals or plans may modify the following sections to incorporate use of a sticker or label that includes this information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in the patient's ID number. This should not be, nor should it contain, the patient's social security or HICN number.

Physician: Fill in the name of the patient's physician.

Date Issued: Fill in the date the notice is delivered to the patient by the hospital/plan.

Insert logo here: Hospitals/plans may elect to place their logo in this space. However, the name, address, and telephone number of the hospital/plan must be immediately under the logo, if not incorporated into the logo. If no logo is used, the name and address and telephone number (including TTY) of the hospital/plan must appear above the title of the form.

BLANK 1: "**This notice gives you a detailed explanation of why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that**

your inpatient hospital services should end on . In the space provided, fill in planned date of discharge.

Bullet # 1: **"Medicare Coverage Policies:"** Place a check next to the applicable Medicare and/or managed care policies. If necessary, hospitals may also use the selection "Other" to list other applicable policies, guidelines or instructions. Hospitals or plans may also preprint frequently used coverage policies or add more space below this line, if necessary. Policies should be written in full sentences and in plain language. In addition, the hospital or plan may attach additional pages or specific policies or discharge criteria to the notice. Any attachments must be included with the copy sent to the QIO as well.

Bullet # 2: **"Specific information about your current medical condition"** Fill in detailed and specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. Use full sentences and plain language.

Bullet # 3: **"If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call."** The hospital/plan should also supply a telephone number for patients to call to get a copy of the relevant documents sent to the QIO. If the hospital/plan has not attached the Medicare policies and/or the Medicare managed care plan policies used to decide the discharge date, the hospital should supply a telephone number for patients to call to obtain copies of this information.

Hospitals or plans may add space below this section to insert a signature line and date, if they so choose.

220 - Hospital Requested Expedited Review
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When a hospital determines that a beneficiary no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a QIO review. Hospitals must notify the beneficiary that the review has been requested. These instructions stem directly from Section 1154(e) of the Act and 42 CFR Part 405.1208.

220.1 - Responsibilities of the Hospital
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The hospital must comply with the following procedures when requesting a QIO review:

Notify the Beneficiary. Hospitals must notify the beneficiary that the hospital has requested a review using a model language notice called the Hospital Requested Review (HRR) described in

this section. See Section 220.4 for General Notice Requirements.

Supply information to the QIO. Hospitals must supply any pertinent information the QIO needs to conduct its review and must make it available by phone or in writing, by close of business on the first full day immediately following the day the hospital submits the request for review.

220.2 - Responsibilities of the QIO
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The QIO's responsibilities are as follows:

Receive request and examine records. The QIO must notify the hospital that it has received the request for review and must notify the hospital if it has not received pertinent records, examine the pertinent records pertaining to the services, and solicit the views of the beneficiary.

Issue a determination. QIOs make their determinations based on criteria in §1154(a) of the Act, which specifies that QIOs will determine whether:

- the services are reasonable and medically necessary,
- the services meet professionally recognized standards of care, and
- the services could be safely be delivered in another setting.

The QIO will make a determination and notify the beneficiary, the hospital, and the physician of its decision within 2 days of the hospital's request and receipt of any pertinent information submitted by the hospital.

Notification. When the QIO issues the determination, it must notify the beneficiary, the hospital, and the physician of its decision by telephone and subsequently in writing. The written notice of the expedited initial determination must contain the following:

- The basis for the determination;
- A detailed rationale for the determination;
- A statement explaining the Medicare payment consequences of the expedited determination and the date of liability if any; and
- A statement informing the beneficiary of his or her appeal rights and the timeframe for requesting an appeal.

220.3 - Effect of the Hospital Requested Expedited Determination (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The expedited determination is binding on the beneficiary, physician, and hospital, except in the following circumstances:

When the beneficiary remains in the hospital. When the beneficiary is still an inpatient in the hospital and is dissatisfied with this determination, he or she may request a reconsideration according to the procedures described in Section 300 of this Chapter.

When the beneficiary is no longer an inpatient in the hospital. If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, this determination is subject to the general claims appeal process (See Chapter 29 of this manual).

220.4 - General Notice Requirements (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Providers should use the HRR to notify a beneficiary that it has requested a QIO review. This notice can be found at http://www.cms.gov/Medicare/Medicare-General- Information/BNI/ Since the HRR uses model language, providers have some flexibility in the preparation of this notice. However, it is highly recommended that hospitals use the model language provided in this instruction, or by their QIO, in order to avoid questions of invalid notice. Providers should utilize the General Notice Requirements in Section 200.5 and the Translation requirements in Section 200.6.1 when preparing the notice.

220.5 - Exhibit 3 – Model Language for Notice of Hospital Requested Review (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospital Identifier

Model Notice of Hospital Requested Review (HRR)

Name of Patient: Name of Physician:
Patient ID Number: Date Issued:

We believe that Medicare will not continue to cover your hospital care because these services are no longer considered medically necessary in your case. Because your doctor disagreed with our finding, the hospital is asking the quality improvement organization (QIO) to review your case. The QIO is an outside reviewer hired by Medicare to look at your case to decide if you are ready to leave the hospital. The name of the QIO is **(insert the name of the QIO)** .

- The QIO will contact you to solicit your views about your case and the care you need.

- You do not need to take any action until you hear from the QIO.

For more information about this notice, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

Signature of Patient or Representative Date Time

240 - Preadmission/Admission Hospital Issued Notice of Noncoverage (HINN)
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Regulations found at 42 CFR Part 476.71 require QIOs to review the medical necessity of hospital discharges and admissions, in addition to other requirements specified in that section of the regulation. Therefore, a beneficiary has a right to request an expedited review by the QIO when a hospital (acting directly or through its utilization review committee) has determined at the time of preadmission or admission, that the beneficiary is facing a non-covered hospital stay because the services are not considered to be reasonable and necessary in this case, the services could be safely provided in another setting, or the care is considered custodial in nature.

The utilization review committee or the hospital may issue a preadmission/admission HINN. QIOs may also issue such notices after having been contacted by a hospital regarding care believed to be medically unnecessary, inappropriate, or custodial. The hospital need not obtain the attending physician's concurrence, or the QIO's, prior to issuing the preadmission/admission HINN. This also applies to direct admissions to swing beds (i.e., the beneficiary is admitted to the swing bed when the hospital determines that the beneficiary does not need hospital-level care, but instead needs only skilled nursing (SNF) or custodial nursing (NF) level services).

240.1 - Delivery of the Preadmission/Admission HINN
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When delivering the Preadmission/Admission HINN, hospitals must follow the notice delivery requirements in Section 200.3.1 regarding:

- In-Person Delivery,
- Notice Delivery to Representatives,
- Ensuring Beneficiary Comprehension.
- Beneficiary Signature and Date.
- Refusal to Sign.
- Notice Delivery and Retention.

240.2 - Notice Delivery Timeframes and Liability
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Preadmission: In preadmission situations, the beneficiary is liable, if admitted, for customary charges for all services furnished during the stay, except for those services for which he or she is eligible to receive payment under Part B.

Admission: If the admission notice is issued at 3 p.m. or earlier on the day of admission, the beneficiary is liable for customary charges for all services furnished after receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B.

If the admission notice is issued after 3 p.m. on the day of admission, the beneficiary is liable for customary charges for all services furnished on the day following the day of receipt of the notice, except for those services for which the beneficiary is eligible to receive payment under Part B.

240.3 - Timeframes for Submitting a Request for a QIO Review
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Preadmission: In preadmission situations, a beneficiary who chooses to exercise the right to a QIO review should request immediately, but no later than 3 calendar days after receipt of the notice, or if admitted, at any point during the stay, an immediate review of the facts related to the admission.

Admission: In admission situations, a beneficiary who chooses to exercise the right to a QIO review should request immediately, or at any point in the stay, an immediate review of the facts related to the admission.

240.4 - Results of the QIO Review
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

If the QIO disagrees with the hospital's determination and says the stay is reasonable and necessary, the beneficiary will be refunded any amount collected except applicable coinsurance and deductibles, and convenience items or services not covered by Medicare.

If the QIO agrees with the hospital determination and says the stay is not reasonable and necessary, the beneficiary will be responsible for all services on the date specified by the QIO.

240.5 - Effect of the QIO Review
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The QIO will send the beneficiary a formal determination of the medical necessity and appropriateness of the hospitalization determination is binding on the beneficiary, the physician, and hospital except in the following circumstances:

Right to pursue a reconsideration. If the beneficiary is still an inpatient in the hospital and is dissatisfied with the determination, he or she may request a reconsideration according to the procedures described in §405.1204 (See Section 300 of this chapter.)

Right to pursue the general claims appeal process. If the beneficiary is no longer an inpatient in the hospital, the determination is subject to the general claims appeal process (See Chapter 29 of this manual.)

240.6 - Exhibit 4 – Model Language for Preadmission/Admission Hospital Issued Notice of Noncoverage

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Hospital Identifier

Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN)
Model Language

Name of Patient: Name of Physician:

Patient ID Number: Date Issued:

We believe that Medicare is not likely to pay for your admission for
(specify service or condition)
because:

it is not considered to be medically necessary

it could be furnished safely in another setting

other .

However, this notice is not an official Medicare decision.

If you disagree with our finding:

- You should talk to your doctor about this notice and any further health care you may need.
- You also have the right to an appeal, that is, an immediate review of your case by a Quality Improvement Organization (QIO). The QIO is an outside

reviewer hired by Medicare to make a formal decision about whether your admission is covered by Medicare. See page 2 for instructions on how to request a review and contact the QIO.

- If you decide to go ahead with the hospitalization, you will have to pay for:

[1]

Continued on Page 2

[1] For preadmission notices, insert: "customary charges for all services furnished during the stay, except for those services for which you are eligible under Part B."
For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

If you want an immediate review of your case:

(insert one of the following as appropriate)

Preadmission:

- Call the QIO immediately at the number listed below, but no later than 3 calendar days after you receive this notice. If you are admitted, you may call the QIO at any point in the stay.

Admission:

- Call the QIO immediately at the number listed below or you may call the QIO at any point during your stay.
- You may also call the QIO for quality of care issues.

QIO Contact Information:

(insert name of QIO in bold)
(insert telephone number of QIO)

If you do not want an immediate review:

- You may still request a review within 30 calendar days from the date of receipt of this notice by calling the QIO at the number below.

Results of the QIO Review:

- The QIO will send you a formal decision about whether your hospitalization

is appropriate according to Medicare's rules, and will tell you about your reconsideration and appeal rights.

- IF THE QIO FINDS YOUR HOSPITAL CARE IS COVERED, you will be refunded any money you may have paid the hospital except for any applicable copays, deductibles, and convenience items or services normally not covered by Medicare.
- IF THE QIO FINDS THAT YOUR HOSPITAL CARE IS NOT COVERED, you are responsible for payment for all services beginning on (specify date) . (see footnote[1] on page 1).

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486- 2048.

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

Signature of Patient or Representative Date Time

260 - Expedited Determinations of Provider Service Terminations (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.1 - Statutory Authority (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Section 1869(b)(1)(F) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554) granted beneficiaries in Original Medicare the right to an expedited determination process to dispute the end of their Medicare covered care in certain provider settings.

This process was implemented though a final rule with comment period, CMS-4004-FC (69 FR 69252, November 26, 2004), effective July 1, 2005. The resulting regulations are located at 42 CFR Part 405, §§405.1200 - 405.1204. There is a parallel process for beneficiaries enrolled in Medicare health plans. (See §§90.2-90.8 in Chapter 13 of the Medicare Managed Care Manual (CMS Pub. 100-16.)

260.2 - Scope (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end: For purposes of this instruction, the term

"beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy). A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B. A NOMNC must be delivered by the SNF when both Part B therapies are ending.

Skilled Nursing Facilities includes beneficiaries receiving Part A and B services in Swing Beds.

260.2.1 - Exceptions
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).

When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).

When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).

When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).

When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).

When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

260.3 - Notice of Medicare Non-Coverage (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The notice is subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the NOMNC. The notice and accompanying instructions may be found online at http://www.cms.gov/Medicare/Medicare-General-Information/BNI

260.3.1 - Alterations to the NOMNC (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages, but must not be condensed to one page.

Providers may include their business logo and contact information on the top of the NOMNC. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, etc.

Providers may include information in the optional "Additional Information" section relevant to the beneficiary's situation.

Note: Including information normally included in the Detailed Explanation of Non-Coverage (DENC) in the "Additional Information" section does not satisfy a provider's responsibility to deliver the DENC, if otherwise required.

260.3.2 - Completing the NOMNC (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Providers must use the OMB-approved NOMNC (CMS-10123). Providers must type or write the following information in the corresponding blanks of the NOMNC:

- Patient name
- Medicare patient number
- Type of coverage (SNF, Home Health, CORF, or Hospice)

- Effective date (last day of coverage)

Note: The effective date is always the last day beneficiaries will receive coverage for their services. Beneficiaries have no liability for services received on this date, but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services. Because SNFs cannot bill the beneficiary for services furnished on the day of (but before the actual moment of) discharge, beneficiaries may leave a SNF the day after the effective date and not face liability for such services.

260.3.3 – Provider Delivery of the NOMNC (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per §260.2. A NOMNC must be delivered even if the beneficiary agrees with the termination of services.

Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of notice delivery.

260.3.4 - Required Delivery Timeframes (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. For example, if the last day of covered SNF care is a Friday, the NOMNC should be delivered no later than the preceding Wednesday.

Note: The two day advance requirement is NOT a 48 hour requirement. For example, if a

patient's last covered home health service is at 10AM on Wednesday and the notice is delivered at 4PM on the prior Monday, it is considered timely.

If home health services are being provided less frequently than daily, the notice must be delivered no later than the next to last visit before Medicare covered services end. For example, if home health care is provided on Tuesdays and Thursdays, and Tuesday is the last day of Medicare covered services, the notice must be delivered no later than the preceding Thursday.

The NOMNC may be delivered earlier than two days preceding the end of covered services. However, delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination.

The notice may not be routinely given at the time services begin. An exception is when the services are expected to last fewer than two days. In these instances, the notice may be given by the provider when services begin.

There is an accepted circumstance when the NOMNC may be delivered sooner than two days or the next to last visit before coverage ends. This exception is limited to cases where a beneficiary receiving home health services is found to no longer be homebound, and thus ineligible for covered home health care. In this circumstance, the NOMNC should be immediately delivered to the beneficiary upon discovery of the loss of homebound status. We expect that in the vast majority of cases, in all settings, the decision of a physician to end care will be based on medical necessity, and thus, foreseeable by the provider within the required time frames for notice delivery.

260.3.5 - Refusal to Sign the NOMNC
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the beneficiary refuses to sign the NOMNC the provider should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the NOMNC remain entitled to an expedited determination.

260.3.6 - Financial Liability for Failure to Deliver a Valid NOMNC
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If a Qualified Independent Contractor (QIO) determines that a provider did not deliver a valid NOMNC to a beneficiary, the provider is financially liable for continued services until two days after the beneficiary receives valid notice, or until the effective date of the valid notice, whichever is later.

260.3.7 - Amending the Date of the NOMNC
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the initial NOMNC was delivered to a beneficiary and the effective date was changed, the provider may amend the notice to reflect the new date. The newer effective date may not be earlier than the effective date of the original notice except in those cases involving the abrupt end of services, as discussed in §260.3.4.

The beneficiary must be verbally notified as soon as possible after the provider is aware of the change. The amended NOMNC must be delivered or mailed to the beneficiary and a copy retained in the beneficiary's file.

If an expedited determination is already in progress, the provider must immediately notify the QIO of the change and provide an amended notice to the QIO.

260.3.8 – NOMNC Delivery to Representatives
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The NOMNC may be delivered to a beneficiary's appointed or authorized representative. Appointed representatives are individuals designated by beneficiaries to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696. http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf See Chapter 29 of the Medicare Claims Processing Manual, section 270.1, for more information on appointed representatives.

CMS usually requires that notification to a beneficiary who has been deemed legally incompetent be made to an authorized representative of the beneficiary. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

However, if a beneficiary is temporarily incapacitated a person (typically, a family member or close friend) whom the provider has determined could reasonable represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the notices described in this section. Such a representative should have the beneficiary's best interests at heart and must act in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In these instances of delivering a notice to an unnamed representative, the provider should annotate the NOMNC with the name of the staff person initiating the contact, the

name of the person contacted, and the date, time, and method (in person or telephone) of the contact. A copy of the NOMNC with this information should be retained in the beneficiary's record.

Note - Exceptions to in person notice delivery. If the NOMNC must be delivered to a representative not living with the beneficiary, the provider is not required to make off-site in- person notice delivery to the representative. The provider must complete the NOMNC as required and telephone the representative at least two days prior to the end of covered services. The provider should inform the representative of the beneficiary's right to appeal a coverage termination decision.

The information provided should include the following:

- The beneficiary's last day of covered services, and the date when the beneficiary's liability is expected to begin.
- The beneficiary's right to appeal a coverage termination decision.
- A description of how to request an appeal by a QIO.
- The deadline to request a review as well as what to do if the deadline is missed.
- The telephone number of the QIO to request the appeal.

The date the provider communicates this information to the representative, whether by telephone or in writing, is considered the receipt date of the NOMNC.

The NOMNC must be annotated with the following information on the day that the provider makes telephone contact:

Reflect that all of the information indicated above was communicated to the representative;

Note the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the beneficiary's medical file.

If the provider chooses to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS) The burden is on the provider to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

The date that someone at the representative's address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary's medical file.

If both the provider and the representative agree, providers may send the notice by fax or e-mail, however, providers fax and e-mail systems must meet the The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

260.3.9 - Notice Retention for the NOMNC
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The provider must retain the original signed NOMNC in the beneficiary's file. The beneficiary should receive a paper copy of the NOMNC that includes all of the required information such as the effective date and covered service at issue. Electronic notice retention is permitted if the NOMNC was delivered electronically.

260.3.10 - Hours of NOMNC Delivery
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Notice delivery should occur within the normal operating hours of the provider. Providers are not expected to extend their hours or days of business solely to meet the requirements of the expedited determination process. However, it is expected that all notices be provided as timely as possible within these constraints.

260.4 - Expedited Determination Process
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.4.1 - Beneficiary Responsibilities
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.4.1.1 - Timeframe for Requesting an Expedited Determination
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A beneficiary who receives a NOMNC and disagrees with the termination of services may request an expedited determination by the appropriate QIO for the state where the services were provided. The beneficiary must contact the QIO by noon of the day before the effective date on the NOMNC. The beneficiary may contact the QIO by telephone or in writing. If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available.

260.4.1.2 - Provide Information to QIO
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The beneficiary must be available to answer questions or supply information requested by the QIO. The beneficiary may, but is not required to, supply additional information to the QIO that he or she believes is pertinent to the case.

260.4.1.3 - Obtain Physician Certification of Risk (Home Health and CORF services only)
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A beneficiary must obtain a physician certification stating that failure to continue home health or CORF services is likely to place the beneficiary's health at significant risk. Without such a certification statement a QIO may not make a determination for service terminations in these settings.

The physician certification is a written statement from any licensed physician contacted by a beneficiary. This is a special certification required only in this expedited determination process for expedited determinations in home health and CORF settings.

A beneficiary may request an expedited determination from a QIO before obtaining this certification of risk. Once the QIO is aware of a review request, it will instruct the beneficiary on how to obtain the necessary certification from a physician.

260.4.2 - Beneficiary Liability During QIO Review
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

A provider may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process, including a reconsideration by a Qualified Independent Contractor (QIC), if applicable, is complete.

260.4.3 - Untimely Requests for Review
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the beneficiary makes an untimely request to the QIO, the QIO will accept the request

for review, but is not required to complete the review within its usual 72-hour deadline. The QIO will make a determination as soon as possible upon receipt of the request.

Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request.

The coverage protections discussed in 260.4.2 do not apply to a beneficiary who makes an untimely request to the QIO.

260.4.4 - Provider Responsibilities
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

When a provider is notified by a QIO of a beneficiary request for an expedited determination, the provider must:

- Deliver the beneficiary a DENC (see §260.4.5) by close of business the day they are notified;

- Supply the QIO with copies of the NOMNC and DENCs by close of business of the day of the QIO notification;

- Supply all information, including medical records, requested by the QIO. The QIO may allow this required information to be supplied via phone, writing, or electronically. If supplied via phone, the provider must keep a written record of the information it provides within the patient record; and

Furnish the beneficiary, at their request, with access to or copies of any documentation it provides to the QIO. The provider may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation. This documentation must be provided to the beneficiary by close of business of the first day after the material is requested.

260.4.5 - The Detailed Explanation of Non-Coverage
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The DENC is subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the DENC. The notice and accompanying instructions may be found online at http://www.cms.gov/Medicare/Medicare-General-Information/BNI. Medicare providers are

responsible for the delivery of the DENC to beneficiaries who request an expedited determination by the QIO.

The DENC must contain the following information:

- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.
- A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered.
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

The provider should make insertions on the notice in Spanish, if necessary. If this is impossible, additional steps should be taken to ensure that the beneficiary comprehends the content of the notice. Providers may resource CMS multilingual services provided through the 1-800-MEDICARE help line if needed.

The delivery must occur in person by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. A provider may also choose to deliver the DENC with the NOMNC.

The DENC does not require a signature but should be annotated in the event of a beneficiary's refusal to accept the notice upon delivery.

Note: An HHA is not required to make a separate trip to the beneficiary's residence solely to deliver a DENC. Upon notification from the QIO of a beneficiary's request for an expedited determination, an HHA may telephone the beneficiary to provide the information contained on the DENC, annotate the DENC with the date and time of telephone contact and file with the beneficiary's records. A hard copy of the DENC should be sent to the beneficiary via tracked mail or other personal courier method by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The burden is on the provider to demonstrate that timely contact was attempted with the beneficiary and that the notice was delivered.

DENC delivery to representatives, DENC hours of delivery, and DENC retention requirements are the same as the NOMNC requirements outlined in §260.3.

Expedited Determination Scenario in a Skilled Nursing Facility - Example

On June 2nd, the SNF delivers a NOMNC to Bob Mills notifying him that his Medicare covered stay will end on June 4th. Bob decides to request an expedited determination.

June 2nd	June 3nd	June 4rd	June 5th	June 6th
NOMNC Delivered Bob receives a NOMNC indicating that his coverage is ending June 4th.	**Bob must** request an expedited determination by noon today.	**NOMNC Effective Date** This is the last day of coverage, as stated on the NOMNC.	**If Bob made his request on June 2nd :** The QIO makes its decision and notifies Bob and the SNF by COB.	**If Bob made his request on June 3rd :** The QIO makes its decision and notifies Bob and the SNF by COB.
	The QIO must notify the SNF of Bob's request for an expedited determination. **The SNF must deliver the DENC to Bob by COB today.** **The SNF must provide relevant medical records to the QIO by COB today.**	**The beneficiary has no liability for this day as this is the last day of coverage in the SNF.**	**If QIO decision is unfavorable:** Beginning today Bob is liable for his stay if he does not leave the SNF.	

260.5 - QIO Responsibilities

(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

260.5.1 - Receive Beneficiary Requests for Expedited Review

(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

QIOs must be available to receive beneficiary requests for review 24 hours a day, 7 days a week.

260.5.2 - Notify Providers and Allow Explanation of Why Covered Services Should End
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

When the QIO receives a request from a beneficiary, the QIO must immediately notify the provider of services that a request for an expedited determination was made. If the request is received after normal working hours, the QIO should notify the provider as soon as possible on the morning after the request was made.

260.5.3 - Validate Delivery of NOMNC
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must validate that the NOMNC included the required elements outlined below:

- Date that coverage of services ends.
- Date that beneficiary's financial liability begins.
- Description of right to an expedited determination (and how to request an expedited determination) and the right to submit relevant information to the QIO.
- Right to detailed information on why the provider believes Medicare will no longer cover services.
- Contact information for QIO in the state where services were delivered.

The QIO should determine that NOMNC delivery was valid if all of the following criteria are met:

- All elements stated above are included.
- The beneficiary signed and dated the notice. If the NOMNC was annotated because the beneficiary refused to sign the notice upon delivery, the QIO may still conduct an expedited determination in these instances.
- Notice was delivered at least two days before services terminate. For a non-residential provider, the notice may be delivered at the next to last visit before services terminate.

Invalidating a NOMNC should be a rare occurrence. The only reasons to invalidate are the lack of one of the criteria stated above or a pattern of minor errors as established by the provider.

If a QIO invalidates a NOMNC, a new NOMNC must be issued to the beneficiary with an effective date at least two days after the beneficiary receives valid notice. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

260.5.4 - Solicit the Views of the Beneficiary (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must solicit the views of the beneficiary who requested the expedited determination.

260.5.5 - Solicit the Views of the Provider (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO must afford the provider an opportunity to explain why the discharge is appropriate.

260.5.6 - Make Determination and Notify Required Parties (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

No later than 72 hours after receipt of the request for an expedited determination, the QIO must make its determination on whether the discharge is appropriate based on medical necessity or other Medicare coverage policies.

Note: If the QIO does not receive supporting information from the provider, it may make its determination based on the evidence at hand, or defer a decision until it receives the necessary information. If this delay results in continued services for the beneficiary, the provider may be held financially liable for these services as determined by the QIO.

The QIO must notify the beneficiary, the beneficiary's physician, and the provider of services of its determination. This notification must include the rationale for the determination and an explanation of Medicare payment consequences and beneficiary liability. QIOs must also inform the beneficiary of the right to an expedited reconsideration by the Qualified Independent Contractor (QIC) and how to request a timely expedited reconsideration. The QIO will make its initial notification via telephone and will follow up with a written determination letter.

260.6 - Effect of a QIO Expedited Determination (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

The QIO determination is binding unless the beneficiary pursues an expedited reconsideration per section 270 of this chapter.

260.6.1 - Right to Pursue an Expedited Reconsideration (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If dissatisfied with the expedited determination, the beneficiary may request an expedited reconsideration according to the procedures described in section 270 of this chapter.

260.6.2 - Effect of QIO Determination on Continuation of Care (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If the QIO decision extends coverage to a period where a physician's orders do not exist, either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care, providers cannot deliver care. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.

If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered if that care is later terminated, per the requirements of this section. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

The QIO decision will affect the necessity of subsequent Advance Beneficiary Notice of Noncoverage (ABN) deliveries.

Example: If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuance of Home Health Advanced Beneficiary Notices (HHABNs) as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA, even though Medicare will not pay, an HHABN with Option Box 1 must be issued to the beneficiary since this would be an initiation of non- covered care.

Example: If covered Skilled Nursing Facility (SNF) care continues following a favorable QIO decision for the beneficiary but later ends due to the end of Medicare coverage, and the patient wishes to continue receiving uncovered care at the SNF, a SNFABN must be issued to the beneficiary.

260.6.3 - Right to Pursue the Standard Claims Appeal Process (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

If a beneficiary receives services of the type at issue in the expedited determination after the coverage end date, and coverage is denied, the beneficiary may appeal the denial within the standard claims appeal process (See Chapter 29 of this manual.)

261 - Expedited Determination Notice Association with Advance Beneficiary Notices
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice delivery must be determined by the individual NOMNC requirements per this section and ABN delivery requirements per §1879 of the Act and per guidance in this chapter. Both the NOMNC and an ABN may be required in certain instances.

Only one notice may be required when Medicare covered care is ending.

Example: A beneficiary is receiving CORF services and all covered CORF care is ending. A NOMNC must be delivered at least two days, or two visits, prior to the end of coverage. If the beneficiary does not continue the CORF services, an ABN should not be issued.

Some situations may require two notices at the end of Medicare covered care.

Example: A beneficiary's Part A stay is ending because skilled level care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial care. The beneficiary must receive the NOMNC two days prior to the end of coverage. A SNFABN must also be delivered before custodial care begins.

It is also possible that no notice is required when Medicare coverage is ending.

Example: A beneficiary exhausts the 100 day benefit in a SNF. In this instance, the NOMNC should not be delivered. The SNFABN is not required in this situation.
However, it can be issued voluntarily, as a courtesy to the beneficiary.

300 - Expedited Reconsiderations
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

A beneficiary who is dissatisfied with a QIO determination can request a reconsideration by an independent review entity (IRE). Such reconsiderations are codified in regulations effective July 1, 2005 (42 CFR 405.1204) but are familiar to inpatient hospital providers as the process previously available under §1155 of the Act. This reconsideration process is the same for hospital and non-hospital providers.

300.1 - The Role of the Beneficiary and Liability
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Submitting a Request: A beneficiary who chooses to exercise the right to an expedited reconsideration must submit a request to the appropriate IRE in writing or by telephone no later than noon of the calendar day following the initial notification (whether by telephone or in writing) of the QIO's determination. The beneficiary, upon request of the QIO, should be available to discuss the case or supply information that the IRE may request. The beneficiary may, but is not required to, submit written evidence to be considered by the IRE.

Untimely Requests: When the beneficiary fails to make a timely request for an expedited reconsideration subsequently may request a reconsideration under the standard claims appeal process (See Chapter 29 of this Manual), but the coverage protection described in Section 300.5 would not extend through this reconsideration, nor would the notification timeframes or the escalation process described in Section 300.2 apply.

300.2 - The Responsibilities of the IRE
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Receipt of the Request. On the day the IRE receives the request for an expedited reconsideration, the IRE must immediately notify the QIO that made the expedited determination and the provider of services of the request for the expedited reconsideration.

Examine Records and Other Information. The IRE must offer the beneficiary and the provider an opportunity to provide further information.

Notification. Unless the beneficiary requests an extension (see below), the IRE must notify the QIO, the beneficiary, and the provider of services of its decision no later than 72 hours after receipt of the request for an expedited reconsideration, and any such records needed for the reconsideration. The initial notification may be done by telephone followed by a written notice that includes:

- The rationale for the reconsideration decision,
- An explanation of the Medicare payment consequences of the determination and the beneficiary's date of liability,

- Information about the beneficiary's right to appeal the IRE's reconsideration decision to an ALJ, including how to request an appeal and the time period for doing so.

Escalation. Unless the beneficiary requests an extension, if the IRE does not issue a decision within 72 hours of receipt of the request, the IRE must notify the beneficiary of his or her right to have the case escalated to the ALJ hearing level if the amount remaining in controversy is $100 or more.

Extensions. A beneficiary who requests an expedited reconsideration may request (either in writing or orally) that an IRE grant such additional time as the beneficiary specifies (not to exceed 14 days) for the reconsideration. If an extension is granted, the deadlines described above under notification, do not apply.

300.3 - The Responsibilities of the QIO
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When an IRE notifies the QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the IRE needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the IRE notifies the QIO of the request for the reconsideration.

At the beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the IRE. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

300.4 - The Responsibilities of the Provider
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The provider may, but is not required to, submit evidence to be considered by an IRE in making its decision. If a provider fails to comply with an IRE's request for additional information beyond that furnished by the QIO for purposes of the expedited determination, the IRE makes its reconsideration decision based on the information available.

300.5 - Coverage During an Expedited Reconsideration
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When a beneficiary makes a timely request for an expedited determination, the provider may not bill the beneficiary for any disputed services until the IRE makes its determination. Beneficiary liability for continued services is based on the QIO's decision.

400 - Part A Medicare Outpatient Observation Notice

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON informs all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or critical access hospital (CAH).

400.1 - Statutory Authority
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) Public Law 114-42, amending Section 1866(a)(1) of the Social Security Act (the Act) (42 U.S.C. 1395cc(a)(1)), by adding a new subparagraph (Y). The NOTICE Act requires hospitals and CAHs to provide written and oral explanation of such written notification to individuals who receive observation services as outpatients for more than 24 hours.

The process for delivery of this notice, the Medicare Outpatient Observation Notice (MOON), was addressed in rulemaking, including a final rule, CMS-1655-F (81 FR 56761, 57037 through 57052, August 22, 2016), effective October 1, 2016. The resulting regulations are located at 42 CFR Part 489.20(y).

400.2 - Scope
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON.
- Beneficiaries for whom Medicare is either the primary or secondary payer.

Notes:

- For purposes of these instructions, the term “beneficiary” means either beneficiary or representative, when a representative is acting for a beneficiary.

- Please see Chapter 13 of the Medicare Managed Care Manual for Medicare Advantage instructions.

The statute expressly provides that the MOON be delivered to beneficiaries who receive observation services as an outpatient for more than 24 hours. In other words, the statute does not require hospitals to deliver the MOON to all beneficiaries receiving outpatient services. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin. However, hospitals and CAHs may deliver the MOON to an individual receiving observation services as an outpatient before such individual has received more than 24 hours of observation services. Allowing delivery of the MOON before an individual has received 24 hours of observation services affords hospitals and CAHs the flexibility to deliver the MOON consistent with any applicable State law that requires notice to outpatients receiving observation services within 24 hours after observation services begin. The flexibility to deliver the MOON any time up to, but no later than, 36 hours after observation services begin also allows hospitals and CAHs to spread out the delivery of the notice and other hospital paperwork in an effort to avoid overwhelming and confusing beneficiaries.

Hospitals Affected by these Instructions. These instructions apply to hospitals as well as CAHs per section 1861(e) and section 1861(mm) of the Social Security Act.

400.3 - Medicare Outpatient Observation Notice (Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The MOON may only be modified as per their accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized MOON. The notice and accompanying instructions may be found online at http://www.cms.gov/Medicare/Medicare-General-Information/BNI

400.3.1 - Alterations to the MOON (Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

In general, the MOON must remain two pages, unless inclusion of additional information per section 400.3.8 or State-specific information per section 400.5 below results in additional page(s). Hospitals and CAHs subject to State law observation notice requirements may attach an additional page to the MOON to supplement the “Additional Information” section in order to communicate additional content required under State law,

or may attach the notice required under State law to the MOON. The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

Hospitals may include their business logo and contact information on the top of the MOON. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, or any other information.

400.3.2 - Completing the MOON
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals must use the OMB-approved MOON (CMS-10611). Hospitals must type or write the following information in the corresponding blanks of the MOON:

- Patient name;
- Patient number; and
- Reason patient is an outpatient.

400.3.3 - Hospital Delivery of the MOON
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals and CAHs must deliver the MOON to beneficiaries in accordance with section 400.2 above. Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification.

Oral notification must consist of an explanation of the standardized written MOON. The format of such oral notification is at the discretion of the hospital or CAH, and may include, but is not limited to, a video format. However, a staff person must always be available to answer questions related to the MOON, both in its written and oral delivery formats.

The hospital or CAH must ensure that the beneficiary or representative signs and dates the MOON to demonstrate that the beneficiary or representative received the notice and understands its contents. Use of assistive devices may be used to obtain a signature.

Electronic issuance of the MOON is permitted. If a hospital or CAH elects to issue a MOON viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the MOON, as specified in 400.3.9, and the required beneficiary specific information inserted, at the time of notice delivery.

400.3.4 - Required Delivery Timeframes
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON must be delivered to a beneficiary who receives observation services as an outpatient for more than 24 hours, and must be delivered not later than 36 hours after observation services begin. The MOON must be delivered before 36 hours following initiation of observation services if the beneficiary is transferred, discharged, or admitted. The MOON may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.

The start time of observation services, for purposes of determining when more than 24 hours of observation services have been received, is the clock time observation services are initiated (furnished to the patient), as documented in the patient's medical record, in accordance with a physician's order. This follows the elapsed clock time, rather than the billed time, associated with the observation services.

400.3.5 - Refusal to Sign the MOON
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital or CAH who presented the written notification. The staff member's signature must include the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the "Additional Information" section of the MOON to include the staff member's signature and certification of delivery. The date and time of refusal is considered to be the date of notice receipt.

400.3.6 - MOON Delivery to Representatives
(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON may be delivered to a beneficiary's appointed representative. Appointed representatives are individuals designated by beneficiaries to act on their behalf. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696. http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. See Chapter 29 of the Medicare Claims Processing Manual, section 270.1, for more information on appointed representatives.

The MOON may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary's behalf (e.g., the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary. However, if a beneficiary is temporarily incapacitated, a person (typically, a family member or close friend) whom the hospital or CAH has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MOON. Such a representative should act in the beneficiary's best interests and in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital or CAH annotates the MOON with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

Note: There is an exception to the in-person notice delivery requirement. If the MOON must be delivered to a representative who is not physically present to receive delivery of the notice, the hospital or CAH is not required to make an off-site delivery to the representative. The hospital or CAH must complete the MOON as required and telephone the representative.

- The information provided telephonically includes all contents of the MOON;
- Note the date and time the hospital or CAH communicates (or makes a good faith attempt to communicate) this information telephonically, per 400.2 above, to the representative is considered the receipt date of the MOON;

- Annotate the "Additional Information" section to reflect that all of the information indicated above was communicated to the representative; and

- Annotate the "Additional Information" section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

Mail a copy of the annotated MOON to the representative the day telephone contact is made.

A hard copy of the MOON must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g., FedEx, UPS). The burden is on the hospital or CAH to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital or CAH and the representative both agree, the hospital or CAH may send the notice by fax or e-mail; however, the hospital or CAH's fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

400.3.7 - Ensuring Beneficiary Comprehension (Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The OMB-approved standardized MOON is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies. Hospitals and CAHs are reminded that recipients of Federal financial assistance have an independent obligation to provide language assistance services to individuals with limited English proficiency (LEP) consistent with section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of Federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973.

400.3.8 - Completing the Additional Information Field of the MOON (Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

This section may be populated with any additional information a hospital wishes to convey to a beneficiary.

Such information may include, but is not limited to:

- Contact information for specific hospital departments or staff members.
- Additional content required under applicable State law related to notice of observation services.
- Part A cost-sharing responsibilities if a beneficiary is admitted as an inpatient before 36 hours following initiation of observation services.
- The date and time of the inpatient admission if a patient is admitted as an inpatient prior to delivery of the MOON.
- Medicare Accountable Care Organization information.

- Hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs.

- Any other information pertaining to the unique circumstances regarding the particular beneficiary.

If a hospital or CAH wishes to add information that cannot be fully included in the "Additional Information" section, an additional page may be attached to supplement the MOON.

400.3.9 - Notice Retention for the MOON (Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The hospital or CAH must retain the original signed MOON in the beneficiary's medical record. The beneficiary receives a paper copy of the MOON that includes all of the required information described in section 400.3.2 and, as applicable, sections 400.3.5, 400.3.6 and 400.3.8. Electronic notice retention is permitted.

400.4 - Intersection with State Observation Notices (Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

As noted in sections 400.3.1 and 400.3.8 above, hospitals and CAHs in States that have State-specific observation notice requirements may add State-required information to the "Additional Information" field, attach an additional page, or attach the notice required under State law to the MOON.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R3698CP	01/27/2017	Medicare Outpatient Observation Notice (MOON) Instructions	02/21/2017	9935
R3695CP	01/20/2017	Medicare Outpatient Observation Notice (MOON) Instructions – Rescinded and replaced by Transmittal 3698	02/10/2017	9935
R3560CP	07/15/2016	Correction of Remark Code Information	10/17/2016	9641
R3187CP	02/06/2015	Language Only Update to Pub 100-04, Chapter 30 for ASC X12 and Claim References	03/06/2015	8992

R2911CP	03/14/2014	Manual Updates to Clarify Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) Requirements Pursuant to Jimmo vs. Sebelius	03/25/2014	8644
R2878CP	02/21/2014	Correction CR - Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131	05/15/2014	8597
R2782CP	09/06/2013	Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131	12/09/2013	8404
R2781CP	09/06/2013	Home Health Change of Care Notice (HHCCN), Form CMS-10280, Manual Instructions. This CR rescinds and fully replaces CR 7323.	12/09/2013	8403
R2711CP	05/24/2013	Expedited Determinations for Provider Service Terminations	08/26/2013	7903
R2480CP	06/01/2012	Advanced Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, Updated Manual Instructions	09/04/2012	7821
R2362CP	12/01/2011	Home Health Advance Beneficiary Notice, (HHABN), Form CMS-R-296	02/03/2012	7323

Rev #	Issue Date	Subject	Impl Date	CR#
R1983CP	06/11/2010	Clarification on Use of the SNF ABN and Denial Letters	07/12/2010	6987
R1587CP	09/05/2008	Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage	03/01/2009	6136
R1257CP	05/25/2007	Important Message From Medicare (IM) and Expedited Determination Procedures for Hospital Discharges	07/02/2007	5622
R1186CP	02/23/2007	Changes to Chapter 30 - Updates to Amount in Controversy Requirement and Correction of Appeals Terminology	05/23/2007	5348
R1035CP	08/18/2006	Updating Publication 100-04, Chapter 30 Regarding the CD ROM Initiative for the Annual "Dear Doctor" Mailing	09/18/2006	5214
R1025CP	08/11/2006	Revised Home Health Advance Beneficiary Notice	09/01/2006	5009
R994CP	06/30/2006	Special Issues Associated with the Advance Beneficiary Notice (ABN) for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities (CORFs)	09/29/2006	5117
R594CP	06/24/2005	Preliminary Instructions: Expedited Determinations/ Reviews for Original Medicare	07/01/2005	3903
R577CP	06/03/2005	Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare	07/01/2005	3903
R001CP	11/01/2003	Initial Publication of Manual	NA	NA

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Medicare Appeals & Denials

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

What you need to do now:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the D. listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.
☐ OPTION 1. I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ OPTION 2. I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ OPTION 3. I don't want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/11 Form Approved OMB No. 0938-0566

Scenario	What Notice(s) To Give	Required?	When To Give Notice
1) Beneficiary drops to a non-skilled level of care • Benefits have not exhausted • Beneficiary **remains in the facility** (Medicare certified bed OR non-Medicare certified bed) • Services constitute custodial care	SNFABN (CMS 10055) or SNF Denial Letter **AND** Notice of Medicare Non-Coverage (NOMNC) (CMS 10123)	Yes	No later than 2 days before covered services end
2) Beneficiary chooses to terminate services, Does **not remain in the facility**	None	N/A	N/A
3) Beneficiary drops to a non-skilled level of care and Beneficiary goes home • Benefits have not exhausted	Notice of Medicare Non-Coverage (NOMNC) (CMS 10123)	Yes	No later than 2 days before covered services end
4) All Part B services on a plan of care are ending	Notice of Medicare Non-Coverage (NOMNC) (CMS 10123)	Yes	No later than 2 days before covered services end
5) Beneficiary requests expedited review from the QIO	Detailed Explanation of Non-Coverage (DENC)	Yes	As soon as notified beneficiary requested QIO

	(CMS 10124)		review
6) Part B service is either • Statutorily excluded from coverage under Medicare, OR • Fails to meet a technical benefit requirement	Revised ABN (CMS-R-131)	No	Prior to providing services
7) Does Not Meet Technical Requirements • No Qualifying Hospital Stay (QHS) • Did not meet 30 day transfer requirement	SNF NEMB (CMS 20014)	No	Prior to providing services

Outpatient Medical Review

Introduction to the Medical Review Process

CMS limits the amount it will pay in one calendar year for medically necessary outpatient (Part B) therapy services, including services furnished by a skilled nursing facility (SNF) to outpatients or residents not otherwise eligible for Part A benefits. The limit is called the "therapy cap." For the FY2016, the therapy cap limit is $1,960 for physical therapy (PT) and speech-language pathology (SLP) services combined; and $1,960 for occupational therapy (OT) services. As part of the exceptions process, there are additional limits known as "thresholds". The threshold amounts of $3,700 for PT and SLP combined and $3,700 for OT have been extended through December 31, 2017. For out-patient therapy services rendered above the threshold amounts, a Medicare contractor may review the medical records to check for medical necessity. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has eliminated the requirement for manual medical review for all claims exceeding the threshold. A targeted review process is currently being put into place. In addition, MACRA has eliminated the use of Recovery Auditors to conduct the reviews. CMS has commissioned Strategic Health Solutions as the Supplemental Medical Review Contractor (SMRC) with performing this medical review on a post-payment basis. Medical reviews analyze claims to determine provider compliance with Medicare coverage, coding and billing rules. Corrective action is taken when providers are found to be non-compliant. The goal of this process is to correct the behavior and prevent further inappropriate billing. The medical review process can be intimidating and overwhelming. Chapter 3 of the Medicare Program Integrity Manual– see below – provides a detailed overview of the post payment review process. Section 3.3.2.7 contains information specific to therapy services.

Physical Therapy
(Centers for Medicare and Medicaid Services: PIM. Chapter 6 - §5.0-5.99)

5 – Medical Review of Part B Intermediary Outpatient Physical Therapy (OPT) Bills - (Rev. 3, 11-22-00)

These instructions specify the criteria for MR of OPT services. Intermediaries shall use the edits listed in PIM Chapter 6, §5.4.1 to assist in conducting focused review within budgeted levels. They may conduct MR using other selection criteria determined to be effective. If an intermediary chooses to use any of the diagnostic edits listed in PIM Chapter 6, §5.4.1, the visits and/or duration parameters may not be changed without approval from CO. They conform to the MR requirements for all outpatient claims from rehabilitation agencies, SNFs, hospitals, and HHAs that provide OPT in addition to home health services.

A. Bill Review

The bill types are:

- Hospital = 12X and 13X;
- SNF = 22X and 23X;
- HHA = 34X;
- Rehabilitation agency, public health agency or clinic = 74X; and
- CORF = 75X

These criteria do not apply to PT services provided under a home health plan of care. Intermediaries evaluate bills based upon the following data that providers must submit on the bill:

- Facility and Patient Identification--Patient name, provider number, HICN, age;
- Diagnosis--List, by ICD-9-CM code, the primary diagnosis for which OPT services were first furnished. Follow with other Dx(s) (diagnoses), applicable to the patient or that influence care;
- Duration--Include the total length of time the provider furnished OPT services (in days) from the date treatment was initiated for the diagnosis (including the last day in the current billing period);
- Number of Visits--Include the total number of patient visits completed since OPT services were initiated for the diagnosis being treated. The provider must enter the total number of visits to date (including the last visit in the billing period) rather than for each separate billing (value code 50);
- Date of Onset (Occurrence Code 11) --The date of onset of the primary PT diagnosis for which the provider furnished OPT services;

- Date Treatment Started (Occurrence Code 35) --Include the date services were initiated for the primary PT Dx being treated; and
- Billing Period--When OPT services began and ended in the billing period ("FROM/THROUGH" dates).

The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits. See PIM Chapter 6, §5.4.1. **Intermediaries do not deny a bill solely on the basis that it exceeds the criteria in these edits.** The edits are **only** for assisting the intermediary in selecting bills for MR or for paying bills that meet Level I. Also, intermediaries do not provide automatic coverage up to these criteria. They neither guarantee minimum coverage nor set maximum coverage limits.

5.1 - Level I Review - (Rev. 3, 11-22-00)

PT edits have been developed for a number of diagnoses. The diagnoses were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with those diagnoses will require skilled OPT. The edits do not specify every diagnosis that may require PT, and the fact that a given diagnosis does not appear in the edits does not create a presumption that OPT services are not necessary or are inappropriate. Intermediaries do not approve or deny claims at Level I for reasonable and necessary. They pay claims that suspend or pass the edits in PIM Chapter 6, §5.4.1 without being subjected to Level II MR. However, they refer all claims that meet the intermediary MR criteria to Level II MR.

For patients receiving other PT services (V57.1) only during an encounter/visit, the appropriate V code for the service is listed first, and, if documented, the diagnosis or problem for which the services are being performed second. The intermediary standard system must program the system to read the diagnosis or problem listed second to determine if it meets one of the Level I edits.

Example: Outpatient rehabilitation services, V57.1 (Other PT), for a patient with multiple sclerosis, 340. The V code is listed first, followed by the code for multiple sclerosis (V57.1, 340). Intermediaries must edit for multiple sclerosis not the V code.) They use this same procedure for V57.81 (Orthotic training), V57.89 (Other specified rehabilitation procedure), and V57.9 (Unspecified rehabilitation procedure).

Evaluate bills at Level I based upon each of the following:

Facility and Patient Identification	Facility name, patient name, provider number, HICN, age

Diagnosis	List the primary diagnosis for which OPT services were furnished by ICD-9-CM code first. List other Dx(s) applicable to the patient or that influence care next.
Duration	The total length of time OPT services have been rendered (in days) from the date treatment was initiated for the diagnosis being treated at the billing provider (including the last day in the current billing period).
Number of Visits	The total number of patient visits completed since OPT services were initiated for the diagnosis being treated by the billing provider. Enter the total number of visits to date (including the last visit in the billing period) rather than for each separate billing (value code 50).
Date Treatment Started (Occurrence Code 35)	The date OPT services were initiated by the billing provider for the primary PT Dx being treated.
Billing Period	When OPT services began and ended in the billing period (from through dates).

5.2 - Level II Review Process - (Rev. 3, 11-22-00)

If a bill is selected for MR, intermediaries refer it to the Level II health professional MR staff. If possible, they have physical therapists review OPT bills. Once the bill is selected for MR, they review the bill in conjunction with medical information submitted by the provider. They use this criteria to perform MR of OPT claims for the bill types identified in PIM Chapter 6, §5ff.

A. Payable OPT Services

Intermediaries pay OPT services only if the services meet all requirements established by Medicare guidelines and regulations. They ensure that each bill subjected to Level II or III MR is supported with adequate medical documentation to make a determination. The documentation must show that the requirements of MIM §§3101.8 and 3148, and in these instructions, are met.

5.3 - MR Documentation for OPT Bills - (Rev. 3, 11-22-00)

An intermediary may also select a bill for intensified review. When a bill is selected for this type of review, they review the bill in conjunction with the medical information submitted. When additional medical information is needed, they may request the data identified below.

When a claim is referred to Level II MR, intermediaries must use the following pertinent data elements in addition to those used for Level I review.

Medical History	Obtain only the medical history which is pertinent to, or influences the OPT treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring OPT, and any pertinent prior PT treatment.
Date of Onset (Occurrence Code 11)	The date of onset of the primary physical therapy diagnosis for which OPT services were being rendered by the billing provider.
Physician Referral and Date	
PT Initial Evaluation and Date	
Plan of Treatment and Date Established	
Date of Last Certification	Obtain the date on which the plan of treatment was last certified by the physician.
Progress Notes	Obtain updated patient status reports concerning the patient's current functional abilities/limitations.

Intermediaries must use the above information along with that in PIM Chapter 6 §5.1, to assess the appropriateness of the OPT plan of treatment and the patient's progress relative to diagnosis, date of onset, etc. The medical information supporting a bill must be specific. Documentation written in general terms, e.g, "strength appears to have increased" or "can now reach higher overhead" or "medical history-chronic arthritis" is insufficient. To make an informed MR decision, request documentation from the provider when incomplete or inadequate documentation is present. The physician's pertinent evaluations, progress notes and opinions about the patient's need for rehabilitation services should also be used (when these are available). Obtain this information from the provider regardless of the document type the provider keeps (i.e., it does not matter whether the baseline evaluation is part of the treatment plan, the progress notes or the medical history, obtain and use this information).

5.3.1 - Medical History - (Rev. 3, 11-22-00)

Medical history is information that is pertinent to, or that influences, the OPT treatment furnished. This may include prior history and treatment by the referring physician, when available. If a history of previous OPT treatment is not available, the provider may provide a general summary regarding the patient's past relevant medical history recorded during the initial evaluation with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior history and treatment by the referring physician must be provided when available.

The patient's medical history, as it relates to the OPT, must include the date of onset and/or exacerbation of the illness or injury. If the patient has had prior OPT for the same condition, intermediaries use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is also necessary for patients who have transferred to a new provider for additional treatment. For example, if surgery has been performed, intermediaries should be aware of the type and date of surgery. The date of onset and type of surgical procedure should be specific for diagnoses such as fractured hip. For other diagnoses, such as arthritis, the date of onset may be general and can be established from the date the patient first required medical treatment. For other types of chronic diagnoses, the history must give the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OPT. For example, a patient that had an amputation several years ago might recently have been fitted with a new prosthesis.

5.3.2 - Evaluation - (Rev. 3, 11-22-00)

Intermediaries should approve a PT initial evaluation, (excluding routine screening) when it is reasonable and necessary for the therapist to determine if there is an expectation that either restorative or maintenance services will be appropriate for the patient's condition. They approve reevaluations when the patient exhibits a demonstrable change in physical functional ability in order to reestablish appropriate treatment goals, or when required for ongoing assessment of the patient's rehabilitation needs. Initial evaluations or reevaluations that are determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed.

The PT evaluation establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's condition must form the basis for the physical therapy treatment goals.

The evaluation must (when possible) include objective tests and measurements which normally will include functional, strength, and range of motion (ROM) assessments. However, for patients with certain neurological conditions (such as upper motor neuron conditions) assessment of strength may not be valid. Where the above tests are not applicable, the physical therapist should document the patient's functional loss and the need for skilled OPT intervention resulting from conditions listed below.

A. Self-Care Dependence

The individual is dependent upon skilled assistance or supervision from another person in self-care activities. These activities include, but are not limited to, significant functional loss or loss of previous functional gains in the ability to:

- Drink;
- Feed;
- Dress; or
- Maintain personal hygiene.

Additionally, this could include care of braces or other adaptive devices.

B. Mobility Dependence

The individual is dependent upon another person for skilled OPT assistance or supervision in such areas as transfer, gait training, stair climbing, and wheelchair maneuvering activities due to, but not limited to:

- Decreased strength;
- Marked muscle spasticity;
- Moderate to severe pain;
- Contractures;
- Loss of coordination;
- Perceptual motor loss;
- Orthotic need; or
- Need for ambulatory or mobility device.

This could involve patients with or without impairment of the lower leg who are partially independent with wheelchair and/or who have significant architectural or environmental barriers.

C. Safety Dependence/Secondary Complications

A safety problem exists when a patient without skilled assistance cannot handle him/herself in a manner that is physically safe. This may extend to the performance of activities of daily living or to acquired secondary complications that could potentially intensify medical sequelae such as fracture nonunion, or decubiti. Some examples of safety dependence may be demonstrated by high probability of falling, swallowing difficulties, severe pain, loss of skin sensation, progressive joint contracture, and infection requiring skilled PT intervention to protect the patient from further complication.

Each patient's condition calls for assessments which are unique to specific impairments. For example, documentation in the treatment of open wounds or ulcerations require other objective and subjective documentation, such as size and depth of the wound, amount and frequency of drainage, signs of granulation, or evidence of infection, etc.

If the goal for any patient is to increase functional abilities, range of motion, or strength, the initial evaluation must measure (if possible) the patient's starting functional abilities, range of motion and strength. If the assessment indicates that joint range of motion or strength is normal, there should be evidence of this assessment in the initial evaluation or progress notes, e.g., "within normal limits." If objective documentation cannot be accomplished for any reason, this should be noted in the initial evaluation or progress notes along with the reason(s).

5.3.3 - Plan of Treatment - (Rev. 3, 11-22-00)

The PT plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." The plan of treatment must include specific modalities/procedures, frequency, and duration of treatment. Changes in the plan of treatment should be submitted with the progress notes.

The plan of treatment must contain the following information concerning the OPT treatment:

Type of Modalities/ Procedures	Should describe the specific nature of the therapy to be provided. Some examples of PT modalities/procedures are deep heat (e.g., diathermy, ultrasound), superficial heat (e.g., hot packs, whirlpool), and therapeutic exercises and gait training.
Frequency of Visits	An estimate of the frequency of treatment to be rendered (e.g., 3x week).
Estimated Duration	Identifies the length of time over which the services are to be rendered and may be expressed in days, weeks, or months.
Diagnoses	Should include the OPT diagnosis if different from the medical diagnosis. For example, the medical diagnosis might be "rheumatoid arthritis." However, the shoulder might be the only area being treated, so the PT diagnosis might be "adhesive capsulitis." In order to establish the OPT diagnosis, diagnostic tests must be used whenever possible.

Functional Goals Should reflect the physical therapist's and/or physician's description of what the patient is expected to achieve as a result of therapy.

Rehabilitation Potential The therapist's and/or physician's expectation concerning the patient's ability to meet the goals at initiation of treatment.

5.3.4 - Progress Reports - (Rev. 3, 11-22-00)

The physical therapist must provide treatment information regarding the current status of the patient during the course of the billing period. The PT progress notes or status summary related to the billing period and any needed reevaluation(s) must update the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, it must be documented in accordance with MIM §3148.3. Additionally, when a patient is continued from one billing period to another, the progress report(s) must reflect comparison between the patient's current functional status and that obtained during the previous billing and/or at the initial evaluation.

Where a valid expectation of improvement exists at the time OPT services are initiated, or thereafter, reasonable and necessary services would be covered even though the expectation may not be realized. However, in such instances, the OPT services are covered only up to the point in time that no further significant functional improvement can be reasonably expected. Progress reports or status summaries by the physician and/or physical therapist must document a continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time. "Significant," in this context, means a generally measurable and substantial increase in the patient's present level of physical functional abilities compared to their level at the time treatment was initiated.

Intermediaries should not interpret the term "significant" so stringently that a claim is denied simply because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer should approve the claim if the services are considered reasonable and necessary and if there is still a reasonable expectation that significant improvement in the patient's **overall safety or functional ability** will occur. However, the physical therapist and/or physician should document such lack of progress and briefly explain the need for continued skilled PT intervention.

MR of rehabilitation claims must be conducted with an understanding that skilled intervention may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is **not** possible. For example, a terminally ill patient may begin to exhibit self care, mobility and/or safety dependence requiring PT services. The fact that full or partial

recovery is not possible or rehabilitation potential is not present, must not affect MR coverage decisions. The deciding factor is always based on whether the services are considered reasonable, effective, treatment for the patient's condition and they require the skills of a physical therapist, or whether they can be safely and effectively carried out by non-skilled personnel, without PT supervision. The reasons for PT intervention must be clear to the reviewer, as well as their goals, prior to a coverage determination. These claims often require review at Level III.

It is essential that the physical therapist document the updated status in a clear, concise, and objective manner. Objective tests and measurements are stressed when these are practical. The physical therapist selects the appropriate method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatment duration. If the method used to demonstrate progress is changed or comparable measures are used; the reasons for the change should be documented, including how the new method relates to the old. The MR staff must have an overview of the purpose of treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

While objective documentation often supports ROM, strength, and other objective measurements; documentation of the patient's current functional status compared to previous reporting period(s) is of paramount importance. The deficits in functional ability should be clear.

Physical therapists must document functional improvements (or lack thereof) as a result of their treatments. Documentation of functional progress must be stated whenever possible in objective, measurable terms. The following illustrates these principles:

A. Pain

Documentation describing the presence or absence of pain and its effect on the patient's functional abilities must be considered in MR decisions. A description of its intensity, type, changing pattern, and location at specific joint ranges of motion will materially aid correct MR decisions. Documentation should describe the limitations placed upon the patient's self care, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

Transcutaneous electrical nerve stimulation (TENS) uses surface electrodes and electrical current to interrupt pain pathways and sensation of pain through peripheral nerves. Generally, it is covered on a trial basis for up to 1 month. Any trial period extending beyond 1 month must be documented as to reason and medical necessity. Intermediaries approve such claims only when the documentation supports the need to assess the patient's suitability for continued treatment with TENS. When it is determined that TENS should be continued as therapy and the patient has

been trained to use the stimulator, it is expected that the stimulator will be employed by the patient at home. Payment may be made under the prosthetic devices benefit for the TENS stimulator. Payment may not be approved for continued OPT treatments with TENS. (See Coverage Issues Manual 35-46 and 65-8.)

B. Therapeutic Exercise

The objective documentation should support the skilled nature of the exercise program, and/or the need for design and establishment of a maintenance exercise program. The goals should be to increase functional abilities in self care, mobility, or patient safety. Documentation should indicate the goals and type of exercise provided and the major muscle groups treated.

Intermediaries approve claims when the therapeutic exercise, because of documented medical complications, the condition of the patient, or complexity of the exercise employed, must be rendered by, or under, the supervision of a physical therapist. For example, while passive and active assistive exercise may often be performed safely and effectively by non-skilled personnel, the presence of fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled PT intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services they require, must be documented by physician orders and/or physical therapy notes. To make correct MR decisions, the patient's losses and/or dependencies in self care, mobility and safety must also be documented. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support why skilled PT is needed for the patient's medical condition and/or safety.

Intermediaries approve establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions supportive personnel and/or family members need to safely and effectively carry out the program. Reevaluation may be approved when reasonable and necessary to readjust the maintenance program to meet the changing needs of the patient. There must be adequate justification for readjusting a maintenance program, e.g., loss of previous functional gain.

C. Cardiac Rehabilitation Exercise

PT is not covered when furnished in connection with cardiac rehabilitation exercise program services unless there also is a diagnosed non-cardiac condition requiring it, e.g., where a patient who is recuperating from an acute phase of heart disease may have had a stroke which requires PT. (See Coverage Issues Manual §35-25.) While the cardiac rehabilitation exercise program may be considered by some a form of PT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are formed under the direct supervision of a

physician. Restrictions on PT coverage do not affect rules regarding coverage or non-coverage of such services when furnished in a hospital inpatient or outpatient setting.

D. Gait Training

The documentation must support the need for skilled gait training to restore functional abilities (or to design and establish a safe maintenance program) which can reasonably be expected to improve the patient's ability to walk or walk more safely. Documentation should clarify the patient's gait deviation, current functional abilities and limitations, and/or safety dependence during gait. Documentation should identify the gait problem being treated, e.g., to correct a balance/incoordination and safety problem or a specific gait deviation, such as a Trendelenberg gait. The type of gait deviation requiring skilled intervention, the functional limitations in mobility, the patient's understanding or lack of understanding of the gait training, and the amount of assistance needed during training is needed to make correct review decisions. The documentation must differentiate skilled gait training rendered from assistive walking, when the patient is walking repetitiously and merely improving distance or endurance (assistive or non-assistive).

E. Transfer Training

The documentation should describe the patient's functional limitations in transfer ability that warrant skilled PT intervention. Documentation should include the special transfer training needed and rendered, and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Intermediaries approve transfer training when the documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the task.

Documentation that supports only repetitious carrying out of the transfer method, once established, and monitored for safety and completion of the task is non-covered care.

F. Electrical Nerve Stimulation

Intermediaries approve reasonable and necessary electrical stimulation to delay or prevent disuse atrophy, but only where the documentation indicates that the nerve supply (including brain, spinal cord and peripheral nerves) to the muscle is intact, and other non-neurological reasons for disuse are causing atrophy. (See Coverage Issues Manual §35-77.)

Electrotherapy for the treatment of facial nerve paralysis, e.g., Bell's palsy is not a covered service. (See Coverage Issues Manual §35-72.)

Intermediaries approve functional electrical stimulation (FES) used to test the suitability for improving the patient's functional ability, e.g., stimulating the dorsiflexors of the ankle to reduce toe drag during the swing-through phase of gait. Documentation must indicate the patient's functional limitation.

G. Biofeedback Therapy

Intermediaries approve claims when the documentation indicates that biofeedback therapy is reasonable and necessary for the patient for muscle reeducation of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Intermediaries deny claims where the documentation supports treatment for ordinary muscle tension states or for psychosomatic conditions. (See Coverage Issues Manual 35-27.)

H. Fabrication of Temporary Prostheses, Braces, and Splints

Intermediaries approve reasonable and necessary fabrication of temporary prostheses, braces and splints, and any reasonable and necessary skilled training needed in their safe and effective use. The documentation must indicate the need for the device and training.

5.3.5 – Certification and Re-certification - (Rev. 3, 11-22-00)

To meet Medicare guidelines, PT services must be certified and re-certified by a physician. They must be furnished while the patient is under the care of a physician. The OPT services may be furnished under a written plan of treatment established by the physician or a qualified physical therapist providing them; however, if the plan is established by a physical therapist, it must be reviewed periodically by the physician.

The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When OPT services are continued under the same plan of treatment for a period of time, the physician must certify at least every 30 days that there is a continuing need for them. Obtain the re-certification at the time the plan of treatment is reviewed since the same 30 day interval is required for the plan's review.

Any changes to the treatment plan established by a physical therapist must be in writing and signed by the physical therapist or by the attending physician. Re-certifications must be signed by the physician who reviewed the plan of treatment. The physician may change a plan of treatment established by the physical therapist, but the physical therapist may not alter a plan of treatment established by a physician.

5.3.6 - PT Forms - (Rev. 3, 11-22-00)

Documentation may be submitted on a specific form or copies of the provider's record. Intermediaries require a specific form if they find it more efficient than using provider records; however, it must capture the MR information required by these instructions. If the intermediary chooses to require a form, it must display the OMB clearance number on each form. The information must be complete. If it is not, they request the missing information and return the bill for the additional information. The information the intermediary requires to review the bill is that required by a physical therapist to properly treat a patient.

5.3.7 - Post-Pay Sample -Denial Rate - (Rev. 3, 11-22-00)

Intermediaries review a random sample of the bills that pass all edits.

Intermediaries conduct a post-pay MR on each claim selected in the random sample. This random sample determines a hospice denial rate by combining the prepay and postpay denials for the same quarter. The rate is calculated by dividing the total charges that the intermediary has determined noncovered by the total charges submitted by the hospice in that quarter. Providers having a 5 percent or higher denial rate in any quarter are placed on 100 percent prepay MR in the subsequent quarter. Providers with a denial rate of less than 5 percent for two (2) consecutive quarters may be removed from 100 percent MR. New providers are handled according to the intermediary's existing procedures.

The intermediary may also investigate abnormal trends uncovered during the random post-pay sample review. The intermediary must alert the RO to the review findings, along with recommendations for corrective actions.

5.4 - Evaluation of PT Edits - (Rev. 3, 11-22-00)

Intermediaries must perform regular evaluations of provider utilization of PT services if they are using the HCFA edits to assist in identifying PT claims for focused MR. They change focused review claims selection based on the results of the evaluation. For example, a provider consistently billing at an aberrant rate just below the edit parameters or providers billing abnormally high utilization for specific diagnostic codes may be subject to focused review.

5.4.1 - OPT Edits - (Rev. 3, 11-22-00)

The following edits do **not** represent normative (or average) treatment. It is prohibited to deny a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR.

Outpatient Medical Review

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
1	Neoplasms	162.0-163.9 185-188.9 165.0-165.9 171.0-172.9 173.5-173.9 174.0-175.9 191.0-192.9 195.3-195.8 201.00-208.9 237.5-237.9 238.0-238.1 239.1-239.3 239.8-239.9 170.2-170.9 225.0-225.9 239.6	13 16 24	38 48 62
2	Parkinson's Disease	332.0-332.1	13	38
3	Meningitis/Encephalitis Intracranial and Intraspinal Abscess Other Extrapyramidal Disease Hydrocephalus and Other Cerebral Degeneration Huntington's Chorea and Other Choreas Spinocerebellar Disease ALS and Other Motor Neuron Diseases other diseases of the spinal cord Unspecified disorder of autonomic N.S. Multiple Sclerosis Demyelinating Diseases of CNS Hemplegia (old unspecified Cerebral palsy Late effects of CVA Other conditions of brain Other unspecified disorders of nervous System Other ill defined cerebrovascular diseases Intracranial injury	320.0-323.9 324.0-324.9 333.0 331.3-331.4 331.89 333.4-333.99 334.0-334.9 335.2-335.9 336.0-336.9 337.9 340 341.8-341.9 342.0-342.9 343.0-343.9 438 348.0-348.9 349.0-349.9 437.0-437.9 851.00-854.19	16	62

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
4	Cerebral hemorrhage, occlusion, stenosis	430-434.9	28	72
	CVA, acute			
	Concussion, Loss of consciousness	436		
	without return to previous level	850.40-850.49		
	Intracranial injury including those			
	with skull FX	800.70-800.89		
		801.70-801.89		
		803.20-803.39		
		803.70-803.89		
		804.70-804.89		
5	Othre paralytic syndromes, paraplegia	344.0-344.9	32	93
	Quadriplegia			
6	Post-herpetic polyneuropathy	053.13	13	40
	Neurosyphilis	094.0-094.9		
	Late effects polio	138		
	Disorders of peripheral nerves	353.0-359.9 (except 357.0)	16	62
	Fx of vertebral column with spinal cord	806.00-806.5	30	93
	Injury	806.8-806.9		
	Spinal cord injury without spinal bone injury. Peripheral nerve injury.	952.00-957.9	24	62
	Acute infective polyneuritis	357.0		
	Disturbance of skin sensation	782.0	12	38
	Bell's palsy	351.0		
	Injury to facial nerve	951.4		
7	Diabetes with peripheral circulatory	250.00-250.01	16	62
	Disorders	250.60-250.71		
	Aortic aneurysm	441.4-441.9		
		442.9		
	Arterial embolism	444.0-446.5		
	Hypertension unspecified	401.9-402.00	13	38
	Diseases of circulatory system	429.9		
	Raynaud's/Buerger's/PVD	443.0-443.9		
	Thrombophlebitis lower extremity	451.11-451.2		
		451.9		
		453.8-453.9		
	Other diseases of arteries and arterioles	447.0-447.9		
	Other disorders of circulatory system			
		459.0-459.9		
	Edema	782.3	10	31

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
	Postmastectomy lymphedema	457.0-457.1		
	other lymphedema			
	Varicose vein with inflammation	454.1		
8	Chronic ulcer of skin	707.0-707.9	29	62
	Hansen's Disease	030.0-030.9	25	62
	Gas gangrene	040.0		
	Diabetes with ulcer manifestation	250.80-250.81		
	Varicose vein with ulcer	454.0		
		454.2		
	Cellulitis	681.00-682.9		
		686.0-686.9		
	Other local infection of skin	785.4		
	Gangrene	875.0-884.2		
	Open wounds	890.0-894.2		
		941.20-941.29		
	Burns (second degree)	942.20-942.29		
		943.20-943.29		
		944.20-944.28		
		945.20-945.20		
		946.2		
		949.2		
		958.3		
	Post traumatic wound infection	915.9, 916.9	13	31
	Superficial injury infected	917.9, 919.9		
9	Psoriasis	696.0-696.1	14	62
	Dermatitis unspecified	692.9	13	31
	Unspecified disorder of skin	709.9		
10	Acute Bronchitis	466.0-466.1	12	31
	Bronchopneumonia	480.0-486		
	Bronchitis, emphysema	490-492.8		
	Chronic airway obstruction	496		
	Symptoms of respiratory system and	786.09	9	31
	other chest symptoms	786.50, 786.52		
	Tuberculosis respiratory Asthma	010.00-012.8		
	unspecified Bronchiectasis	493.9, 494		
11	Chronic renal failure	585	12	38
	Acute renal failure	584.9		
	Nephritis, nephropathy	583.9		
	Renal failure unspecified	586		
	Unspecified lesion in kidney	593.9		
12	Lupus erythematosus	695.4	16	62
	Diffuse disease of connective tissue	710.0-710.9		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
	Arthropathy associated with infection	711.00-711.99		
	Arthropathy associated with other Disorders	71.0-713.8		
	Rheumatoid arthritis and Inflammatory polyarthropathies	714.0-714.9		
	Gouty arthopathy	274.0		
13	Osteoarthrosis and allied disorders	715.00-716.99	13	31
14	T.M.J. disorders	524.6	13	38
	Internal derangement of joint, other	717.0-719.99		
	Derangement of joint and other			
	Unspecified disorders of joint			
15	Dorsopathies	720.0-724.9	13	31
	Ostetis deformans	731.0		
	Aseptic necrosis	733.40-733.49		
	Disorder of bone and cartilage	733.81-733.91		
	Chondromalacia	733.92		
	Other acquired deformities	733.99		
		737.0-737.9		
		738.4-738.6		
		738.8-738.9		
	Anomalies of spine	756.10-756.12		
		756.19, 756.9		
		730.00-730.29	16	62
	Osteomyelitis	736.00-736.9		
	Acquired deformities	755.31		
		733.00-733.09	10	31
	Osteoporosis	733.1	12	31
	Pathological Fx			
16	Peripheral enthesopathies and allied Syndromes	725-729.9 (excluding 727.1 and 727.40-727.49)	13	31
	Disorders of muscles, tendons and their			
	Attachments and other soft tissues			
	Herpes zoster	053.10-053.12		
		053.8-053.9		
17	Senile dementia	290.0-290.10	10	31
	Other cerebral degenerations	331.0-331.3		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
		331.9		
	Nonallopathic lesions	739.1-739.7		
	Gait disturbance due to debility	780.7		
	Syncope/collapse convulsions, dizziness	780.2-780.4		
	Abnormal posture			
	Debility, unspecified and other	781.9		
	Abnormal			
	Involuntary movements	799.3		
		799.8-799.9		
	Abnormality of gait incoordination	781.0	12	38
	Transient paralysis of limb T.I.A.	781.2-781.4		
		435.0-435.9	13	38
18	Fx of vertebral column without cord Injury	805.00-805.98	13	38
	Fx of rib, sternum	807.00-807.49	12	38
	Fx of clavicle	810.00-810.03		
	Fx of unspecified bone	829.0-829.1		
19	Fx of pelvis	808.0-808.9	18	62
	Fx of femur	820.0-821.39		
20	Fx of patella	822.0-822.1	18	62
	Fx of tibia and fibula	823.00-823.92		
	Fx of ankle, tarsals, metatarsals	824.0-825.39	13	62
	Fx, other multiple	827.0-82.1		
21	Fx of humerus, F of radius and ulna, Fx of carpals, Fx of metacarpals and Phalanges	811.00-819.1	18	62
22	Dislocations	830.0-839.9	18	62
	Crushing injury	927.0-929.9		
23	Sprains and strains	840.0-848.9	13	31
	Late effects of strains, sprains	905.6-905.7		
	Dislocation			
	Contusions	922.0-924.9		
	Injury, other unspecified	959.0-959.9		
24	Amputation upper	885.0-887.7	24	62
	Lower	895.0-897.7	28	93
25	Burns (3rd and 4th degree)	941.30-941.59	32	93
		942.30-942.59		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
		943.30-943.59 944.30-944.58 945.30-945.59 946.3-946.5 949.3-949.5		
26	Joint replacement Aortocornary bypass Neuropacemaker Convalescence following FX Followup exam FX Fitting and adjustment of prosthetic care Removal internal fixation device Observation for specified condition Orthopedic aftercare Other aftercare following surgery Other specified aftercare Unspecified aftercare Other followup	V43.6 V45.81 V45.89 V66.4 V67.4 V52.0-52.1 V54.0 V71.8 V54.8-V54.9 V58.4 V58.8 V58.9 V67.59, V67.9	13 10 12 	38 31 38
	Late effects Fx Late effects tendon injury Late effects amputation Late effects of injuries Complications of surgical and medical Care	905.1-905.5 905.8 905.9 906.0-909.9 996.4 996.60-997.3 997.60-997.9 998.3, 998.5 998.8-998.9 999.9	 13 	 38

Occupational Therapy

7 – Medical Review of Part B Intermediary Outpatient OT Bills - (Rev. 3, 11-22-00)

The following is criteria for MR of OT services. Intermediaries use the OT edits to assist the reviewer in conducting focused MR within the intermediary budgeted levels. They focus their review using other selection criteria which is determined to be effective. If they choose to use any of the diagnostic edits listed, they do not change the visits and/or duration parameters without approval from CO. They must conform to the MR requirements for all outpatient claims from rehabilitation agencies, SNFs, hospitals, and HHAs that provide OT in addition to home health services.

The bill types are:

- Hospital = 12X and 13X;
- SNF = 22X and 23X;
- HHA = 34X,
- Rehabilitation agency, public health agency or clinic = 74X; and
- CORF = 75X.

These criteria do not apply to OT services provided under a home health plan of care. The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits.

Denial of a bill solely on the basis that it exceeds the criteria in the edits is prohibited.

The edits are only for assisting the intermediary in selecting bills to review or for paying bills if they meet Level I criteria. They do not provide automatic coverage up to these criteria. They neither guarantee minimum nor set maximum coverage limits.

7.1 - Level I Review - (Rev. 3, 11-22-00)

OT edits have been developed for a number of diagnoses. The diagnoses were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with these diagnoses will require skilled OT. The edits do not specify every diagnosis which may require OT, and the fact that a given diagnosis does not appear in the edits does not create a presumption that OT services are not necessary or are inappropriate. Intermediaries do

not approve or deny claims at Level I for medical necessity. They pay claims that suspend or pass the edits in Exhibit 1 without being subjected to Level II MR. However, they refer all claims that meet the focused MR criteria to Level II MR.

For patients receiving OT services only (V57.2) during an encounter/visit, providers list the appropriate V code for the service first, and, if documented, list the diagnosis or problem for which the services are performed second. The intermediary standard system must be programmed to read the diagnosis or problem listed second to determine if it meets the Level I OT edits.

Example: Outpatient rehabilitation services, V57.2, for a patient with multiple sclerosis, 340. The V code will be listed first, followed by the code for multiple sclerosis (V57.2, 340). Intermediaries must edit for multiple sclerosis not the V code. They use this same procedure for V57.81 (Orthotic training) V57.89 (Other) and V57.9 (Unspecified rehabilitation procedure).

The provider must submit the following information on the claim and the intermediary must evaluate bills at Level I based upon:

Facility and Patient Identification	Facility name, patient name, provider number, HICN, age.
Diagnosis	List the primary diagnosis for which OT services were furnished by ICD-9-CM code first. List other Dx(s) applicable to the patient or that influence care second.
Duration	The total length of time OT services have been furnished (in days) from the date treatment was initiated for the diagnosis being treated at the billing provider (including the last day in the current billing period).
Number of Visits	The total number of patient visits completed since OT services were initiated for the diagnosis being treated by the billing provider. The total visits to date (including the last visit in the billing period) must be given rather than for each separate bill (value code 51).
Date Treatment Started (Occurrence Code 44)	The date OT services were initiated by the billing provider for the primary medical Dx for which OT services are furnished.

Billing Period	When OT services began and ended in the billing period (from/through dates).

7.2 - Level II Review Process - (Rev. 3, 11-22-00)

If a bill is selected for intensified review, intermediaries refer it to the Level II health professional MR staff. If possible, they have occupational therapists review OT bills.
Once the bill is selected for review, they review it in conjunction with the medical information submitted by the provider.

A. Payable OT Services - (Rev).

Intermediaries reimburse OT services only if they meet all requirements established by the Medicare guidelines and regulations. Each bill for OT services that is subjected to Level II MR must be supported with adequate medical documentation for the reviewer to make a determination. (For additional requirements see MIM §§3101.9 and 3148.)

7.3 – Medical Review Documentation - (Rev. 3, 11-22-00)

When a claim is referred to Level II review, intermediaries use the following pertinent data elements in addition to those used for Level I review:

Medical History	Obtain only the medical history which is pertinent to, or influences the OT treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring OT, and any pertinent prior OT treatment.
Date of Onset (Occurrence Code 11)	The date of onset or exacerbation of the primary medical diagnosis for which OT services are being rendered by the billing provider.
Physician Referral and Date	
OT Initial Evaluation and Date	
Plan of Treatment and Date Established	

Date of Last Certification Obtain the date on which the plan of treatment was last certified by the physician.

Progress Notes Obtain updated patient status reports concerning the patient's current functional abilities/limitations.

The following explains specific Level II documentation principles:

7.3.1 - Medical History - (Rev. 3, 11-22-00)

If a history of previous OT treatment is not available, the provider supplies a general summary regarding the patient's past relevant medical history recorded during the initial evaluation with the patient/family or through contact with the referring physician. Information regarding prior OT treatment for the current condition, progress made, and treatment by the referring physician is provided when available. The level of function prior to the current exacerbation or onset is described.

The patient's medical history as it relates to OT, includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is necessary for patients who have transferred to a new provider. For example, if surgery has been performed, obtain the type and date. The date of onset and type of surgical procedure should be specific for diagnoses such as fractures. For other diagnoses, such as arthritis, the date of onset may be general. Establish it from the date the patient first required medical treatment. For other types of chronic diagnoses, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OT.

7.3.2 - Evaluation - (Rev. 3, 11-22-00)

Intermediaries approve an OT initial evaluation, (excluding routine screening) when it is reasonable and necessary for the therapist to determine if there is an expectation that either restorative or maintenance services are appropriate. They approve reevaluations when the patient exhibits a demonstrable change in physical functional ability, requiring reestablishment of appropriate treatment goals, or when reasonable and necessary, for ongoing assessment of the patient's rehabilitation needs. They approve initial evaluations or reevaluations that are reasonable and necessary based on the patient's condition, even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed.

The OT evaluation establishes the physical and cognitive baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's functional deficits and level of assistance needed forms the basis for the OT goals. Objective tests and measurements are used (when possible) to establish base-line data. The provider documents the patient's functional loss and the level of assistance requiring skilled OT intervention resulting from conditions such as those listed below.

A. ADL Dependence

The individual is dependent upon skilled intervention for performance of ADL. These include, but are not limited to, significant physical and/or cognitive functional loss, or loss of previous functional gains in the ability to:

- Feed, eat, drink;
- Bathe;
- Dress;
- Perform personal hygiene;
- Groom; or
- Perform toileting.

This could include management and care of orthoses and/or adaptive equipment, or customized therapeutic adaptations.

B. Functional Limitation

The individual is dependent upon skilled OT intervention in functional training, observation, assessment, and environmental adaptation due, but not limited to:

- Lack of awareness of sensory cues, or safety hazards;
- Impaired attention span;
- Impaired strength;
- In-coordination;
- Abnormal muscle tone;
- Range of motion limitations;

- Impaired body scheme;
- Perceptual deficits;
- Impaired balance/head control; and
- Environmental barriers.

C. Safety Dependence/Secondary Complications

A safety problem exists when a patient, without skilled OT intervention, cannot handle him/herself in a manner that is physically and/or cognitively safe. This may extend to daily living or to acquired secondary complications which could potentially intensify medical sequelae such as fracture nonunion, or skin breakdown. Safety dependence may be demonstrated by high probability of falling, lack of environmental safety awareness, swallowing difficulties, abnormal aggressive/destructive behavior, severe pain, loss of skin sensation, progressive joint contracture, and joint protection/preservation requiring skilled OT intervention to protect the patient from further medical complication(s).

If the goal is to increase the patient's functional abilities and decrease the level of assistance needed, the initial evaluation must measure the patient's starting functional abilities and level of assistance required.

7.3.3 - Plan of Treatment - (Rev. 3, 11-22-00)

The OT plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." The provider submits changes in the plan with the progress notes. The plan must include the following information.

Type of OT Procedures	Describes the specific nature of the therapy to be provided.
Frequency of Visits	An estimate of the frequency of treatment to be rendered (e.g., 3x week).The provider's medical documentation should justify the intensity of services rendered. This is crucial when they are given more frequently than 3 times a week.
Estimated Duration	Identifies the length of time over which the services are to be rendered in days, weeks, or months.

Diagnoses	Includes the OT diagnosis if different from the medical diagnosis. The OT diagnosis should be based on objective tests, whenever possible.
Functional OT Goals (short or long-term)	Reflects the occupational therapist's and/or physician's description of what functional physical/cognitive abilities the patient is expected to achieve. Assume that factors may change or influence the level of achievement. If this occurs, the occupational therapist or physician explains the factors which led to the change in functional goal(s).
Rehabilitation Potential	The occupational therapist's and/or physician's expectation concerning the patient's ability to meet the established goals.

7.3.4 - Progress Reports - (Rev. 3, 11-22-00)

Progress reports or treatment summary for the billing period is used by the provider to document and report the following information:

- The patient's initial functional status;
- The patient's functional status and progress (or lack thereof) specific for this reporting period; including clinical findings (amount of physical and/or cognitive assistance needed, range of motion, muscle strength, unaffected limb measurements, etc.); and
- The patient's expected rehabilitation potential.

Where a valid expectation of improvement exists, the services are covered even though the expectation may not be realized. However, in such instances, the OT services are covered only to the time that no further significant practical improvement can be expected. Progress reports or status summaries must document a continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of functional independence and competence, compared to that when treatment was initiated. Intermediaries should not interpret the term "significant" so stringently that the they deny a claim simply because of a temporary setback in the patient's progress. For example, a patient may experience an intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's overall safety or functional ability

will occur. However, the provider should document the lack of progress and justify the need for continued skilled OT.

The provider must provide treatment information regarding the status of the patient during the billing period. The provider's progress notes and any needed reevaluation(s) must update the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, it must be documented. Additionally, when a patient is continued from one billing period to another, the progress report(s) must reflect the comparisons between the patient's current functional status and that during the previous billing and/or initial evaluation.

Intermediaries conduct a MR of claims with an understanding that skilled intervention may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is not possible. For example, a terminally ill patient may begin to exhibit ADL, mobility and/or safety dependence requiring OT. The fact that full or partial recovery is not possible or rehabilitation potential is not present, does not affect MR coverage decisions. The deciding factor is whether the services are considered reasonable, effective, treatment for the patient's condition and they require the skills of an occupational therapist, or whether they can be safely and effectively carried out by non-skilled personnel. The reasons for OT must be clear, as well as its goals, prior to a favorable coverage determination. They often require Level III review.

It is essential that the provider documents the updated status in a clear, concise, and objective manner. Objective tests and measurements are stressed when they are practical. The occupational therapist selects the method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatment duration. If the method used is changed, the reasons for the change should be documented, including how the new method relates to the old. The reviewer must have an overview of the purpose of treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

Documentation of the patient's current functional status and level of assistance required compared to previous reporting period(s) is of paramount importance. The deficits in functional ability should be clear. Occupational therapists must document functional improvements (or lack thereof) as a result of their treatments. Documentation of functional progress must be stated in objective, measurable terms. The following illustrate these principles and demonstrate that significant changes may occur in one or more of the assistance levels:

7.3.4.1 - Change in Level of Assistance - (Rev. 3, 11-22-00)

Occupational therapist's document assistance levels by describing the relationship between functional activities and the need for assistance. Within the assistance levels of minimum, moderate, and maximum there are intermediate gradations of improvement based on changes in behavior and response to assistance. Improvements at each level must be documented to compare the current cognitive and/or physical level achieved to that previously achieved.

While cognitive assistance often is the more severe and persistent disability, physical assistance often is the major obstacle to successful outcomes and subsequent discharge. Intermediaries should interpret the levels as follows:

A. Total Assistance

Total assistance is the need for 100 percent assistance by one or more persons to perform all physical activities and/or cognitive assistance to elicit a functional response to an external stimulation. An individual requires total assistance if the documentation indicates the patient is only able to initiate minimal voluntary motor actions and requires the skill of an occupational therapist to develop a therapeutic program or implement a maintenance program to prevent, or minimize, deterioration.

A cognitively impaired patient requires total assistance when documentation shows external stimuli are required to elicit automatic actions such as swallowing or responding to auditory stimuli. Skills of an occupational therapist are needed to identify and apply strategies for eliciting appropriate, consistent automatic responses to external stimuli.

B. Maximum Assistance

Maximum assistance is the need for 75 percent assistance by one person to physically perform any part of a functional activity and/or cognitive assistance to perform gross motor actions in response to direction. Patients require such assistance if maximum OT physical support and proprioceptive stimulation is needed for performance of each step of a functional activity, every time it is performed. A cognitively impaired patient, at this level, may need proprioceptive stimulation and/or one-to-one demonstration by the occupational therapist due to the patient's lack of cognitive awareness of other people or objects.

C. Moderate Assistance

Moderate assistance is the need for 50 percent assistance by one person to perform physical activities or constant cognitive assistance to sustain/complete simple, repetitive activities safely. A physically impaired patient requires moderate assistance if documentation indicates that

moderate OT physical support and proprioceptive stimulation is needed each time to perform a functional activity.

The records submitted should state how a cognitively impaired patient requires intermittent one-to-one demonstration or intermittent cueing (physical or verbal) throughout the activity. Moderate assistance is needed when the occupational therapist/care-giver needs to be in the immediate environment to progress the patient through a sequence to complete an activity. This level of assistance is required to halt continued repetition of a task and to prevent unsafe, erratic or unpredictable actions that interfere with appropriate sequencing.

D. Minimum Assistance

Minimum assistance is the need for 25 percent assistance by one person for physical activities and/or periodic, cognitive assistance to perform functional activities safely. A physically impaired patient requires minimum assistance if documentation indicates that activities can only be performed after physical set-up by the occupational therapist or care-giver, and if physical help is needed to initiate, or sustain an activity. A review of alternate procedures, sequences and methods may be required. A cognitively impaired patient requires minimal assistance if documentation indicates help is needed in performing known activities to correct repeated mistakes, to check for compliance with established safety procedures, or to solve problems posed by unexpected hazards.

E. Standby Assistance

Standby assistance is the need for supervision by one person for the patient to perform new procedures adapted by the therapist for safe and effective performance. A patient requires such assistance when errors are demonstrated or the need for safety precautions are not always anticipated by the patient.

F. Independent Status

Independent status means that no physical or cognitive assistance is required to perform functional activities. Patients at this level are able to implement the selected courses of action, demonstrate lack of errors and anticipate safety hazards in familiar and new situations.

7.3.4.2 - Change in Response to Treatment Within Each Level of Assistance - (Rev. 3, 11-22-00)

Significant improvement must be indicated by documenting a change in one or more of the following categories of patient responses:

A. Refusals

The patient may respond by refusing to attempt an activity because of fear or pain. The documentation should indicate the activity refused, the reasons, and how the OT plan addresses them. These responses are often secondary to a change in medical status or medications. If the refusals continue over several days, the therapy program should be put on "hold" until the patient is willing to attempt functional activities.

For the cognitively impaired patient, refusal to perform an activity can escalate into aggressive, destructive or verbally abusive behavior if the therapist or care-giver presses the patient to perform. In these cases, a reduction in these behaviors is considered significant progress, but must be documented, including the skilled OT provided to reduce the abnormal behavior.

For the psychiatrically impaired patient, refusals to participate in an activity frequently are symptoms of the diagnosis. The patient should not be put on a "hold" status due to refusals. If the documentation indicates that the patient is receiving OT, is contacted regularly, and is actively encouraged to participate, intermediaries medically review the claim to determine if reasonable and necessary skilled care has been rendered.

B. Inconsistency

The patient may respond by inconsistently performing functional tasks from day-to-day or within a treatment session. Intermediaries approve the claim when the documentation indicates a significant progression in consistency of performance of functional tasks within the same level of assistance.

C. Generalization

The patient may respond by applying previously learned concepts for performing an activity to another, similar activity. The records submitted should document a significant increase in scope of activities that the patient can perform, their type, and the skilled OT services rendered.

Examples of a new skilled functional activity are:

- Adding teaching of lower body dressing to a current program of upper body dressing;
- Increasing the ability to perform personal hygiene activities for health and social acceptance.

Examples of a new skilled compensatory technique (with or without adapted equipment) are:

- Teaching a patient techniques such as one-handed shoe tying;
- Teaching the use of a button hook for buttoning shirt buttons.

The acceptable length of time in treatment for various disorders is determined by the patient's documented functional abilities and progress.

7.3.5 - Level of Complexity of Treatment - (Rev. 3, 11-22-00)

Intermediaries base decisions on the level of complexity of the services rendered by the occupational therapist and not what the patient is asked to do.

A. Skilled OT

The documentation must indicate that the severity of the physical, emotional, perceptual, or cognitive disability requires complex and sophisticated knowledge to identify current and potential capabilities. In addition, intermediaries consider instructions required by the patient and/or the patient's care-givers. Instructions may be required for activities that most healthy people take for granted. The special knowledge of an occupational therapist is required to decrease or eliminate limitations in functional activity performance. Occupational therapists must often address underlying factors which interfere with specific activities. These factors could be cognitive, sensory, or perceptual deficits.

The occupational therapist modifies the specific activity by using adapted equipment, making changes in the environment, altering procedures for accomplishing the task, and providing specialized assistance to meet the patient's current and potential abilities. Skilled services include, but are not limited to reasonable and necessary:

- Patient evaluations;
- Determinations of effective goals and services with the patient and patient's caregivers and other medical professionals;
- Analyzing and modifying functional tasks;
- Determination that the modified task obtains optimum performance through tests and measurements;
- Providing instructions of the task(s) to the patient, family, care-givers; and
- Periodically reevaluating the patient's status with corresponding readjustment of the OT program.

A period of practice may be approved for the patient and/or patient's care-givers to learn the steps of the task, to verify the task's effectiveness in improving function, and to check for safe and consistent performance.

B. Non-skilled OT

When the documentation indicates a patient has attained the therapy goals or has reached the point where no further significant improvement can be expected, the skills of an occupational therapist are not required to maintain function at the level to which it has been restored.

Examples of maintenance procedures:

- Daily feeding programs after the adapted procedures are in place;
- Routine exercise and strengthening programs;
- The practice of coordination and self-care skills on a daily basis; and
- Presenting information on energy conservation or pacing, but not having the patient perform the activity.

The intermediary may approve a claim because the patient requires the judgment and skills of the occupational therapist to design a safe and effective maintenance program and make periodic checks of its effectiveness. The services of an occupational therapist in carrying out the established maintenance program are not reasonable and necessary for the treatment of illness or injury and may not be approved.

7.3.6 - Reporting on New Episode or Condition - (Rev. 3, 11-22-00)

Occasionally, a patient who is receiving or who has received OT services experiences a new illness. The provider must document the significance of any change to the patient's functional capabilities. This may be through pre and post episodic nursing notes or physician reports. If the patient is receiving treatment, it might be lengthened. If the patient had completed treatment a significant change in the patient's functional status must be documented to warrant a new treatment plan.

7.4 - Other MR Considerations - (Rev. 3, 11-22-00)

A. Pain

Intermediaries consider documentation describing the presence or absence of pain and its effect on the patient's functional abilities in MR decisions. A description of its intensity, type, changing pattern, and location at specific joint ranges of motion materially aids correct decisions.

Documentation should describe the limitations placed upon the patient's ADL, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

B. Therapeutic Programs

The objective documentation should support the skilled nature of the program, and/or the need for the design and establishment of a maintenance OT program. The goals should be to increase functional abilities in ADL, mobility or patient safety. Documentation should indicate the goals and type of program provided.

Intermediaries may approve claims when the therapeutic program, because of documented medical complications, the condition of the patient, or complexity of the OT employed, must be rendered by, or under, the supervision of an occupational therapist. For example, while functional ADL may be performed safely and effectively by non-skilled personnel, fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled occupational therapist intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services they require, must be documented by physician orders and/or occupational therapist notes. For correct MR decisions, the patient's losses and/or dependencies in ADL, mobility and safety must be documented. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless documentation supports why skilled OT is needed for the patient's medical condition and/or safety.

Intermediaries approve the establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions to supportive personnel and/or family members need to safely and effectively carry it out. They may approve reevaluation when reasonable and necessary to readjust the maintenance program to meet the changing needs of the patient. There must be justification for readjusting a maintenance program, e.g., loss of previous functional gains.

C. Cardiac Rehabilitation Exercise

OT is not covered when furnished in connection with cardiac rehabilitation exercise program services (see Coverage Issues Manual 35-25) unless there is also a diagnosed non-cardiac condition requiring it, e.g., a patient who is recuperating from an acute phase of heart disease may have had a stroke which requires OT. (While the cardiac rehabilitation exercise program may be considered by some a form of OT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician.)

D. Transfer Training

The documentation should describe the patient's functional limitations in transfer ability that warrant skilled OT intervention. Documentation includes the special transfer training needed to perform functional daily living skills and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Intermediaries approve transfer training when the documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the activities of daily living or mobility.

Documentation that supports only repetitious carrying out of the transfer method once established, and monitored for safety and completion does not show covered care.

E. Fabrication of and Training in Use of Orthoses, Prostheses and Adaptive Equipment

Intermediaries approve reasonable and necessary fabrication of orthoses, prostheses, adaptive equipment, and reasonable and necessary skilled training needed in their safe and effective use, if documentation indicates the need for the device and training in its use.

F. OT Forms

Documentation may be submitted on a specific form the intermediary requires or may be copies of the provider's record. However, the form must capture the needed MR information. If the reviewer chooses to require a particular form, show the OMB clearance number. The information submitted must be complete. If it is not, intermediaries return the bill for the additional information. The information required to review the bill is that which is required by an occupational therapist to properly treat a patient.

G. Certification and Re-certification

OT services must be certified and re-certified by a physician and must be furnished while the patient is under the care of a physician. OT services must be furnished under a written plan of treatment established by the physician or a qualified occupational therapist. If the plan is established by an occupational therapist, it must be reviewed periodically by the physician.

The plan of treatment must be established (reduced to writing by either professional or the provider when it makes a written record of oral orders) before treatment is begun. When outpatient OT services are continued under the same plan of treatment for a period of time, the physician must certify at least at 30-day intervals that there is a continuing need for them. Intermediaries obtain the re-certification when reviewing the plan of treatment since the same interval of at least 30 days is required for review of the plans. A re-certification must be signed

by the physician, who reviewed the plan of treatment. Any changes to the treatment plan established by the occupational therapist must be in writing and signed by the therapist or by the attending physician. The physician may change a plan of treatment established by the occupational therapist. However, the occupational therapist may not alter a plan of treatment established by a physician.

7.4.1 - OT Availability - (Rev. 3, 11-22-00)

Two or more disciplines may provide therapy services to the same patient. There may also be occasions where these services are duplicated. In many instances, the description of the services appears duplicated, but the documentation proves that they are not. Some examples where there is **not** a duplication include:

A. Transfers

PT instructs the patient in transfers to achieve the level of safety with the techniques. OT utilizes transfers as they relate to the performance of daily living skills (e.g., transfer from wheelchair to bathtub).

B. Pulmonary

PT instructs the patient in an adapted breathing technique. OT carries the breathing retraining into activities of daily living.

C. Hip Fractures/Arthroplasties

PT instructs the patient in hip precautions and gait training. OT reinforces the training with precautions for activities of daily living, e.g., lower extremity dressing, toileting, and bathing.

D. CVA

PT utilizes upper extremity neurodevelopmental (NDT) techniques to assist the patient in positioning the upper extremities on a walker and in gait training. OT utilizes NDT techniques to increase the functional use of the upper extremity for dressing, bathing, grooming, etc.

7.5 - FMR Analysis - (Rev. 3, 11-22-00)

The HCFA edits may assist the intermediary in identifying OT claims for FMR. Intermediaries perform regular evaluations of provider claims which pass or fail the edits. They must change the focused review claims selection based on the results of the evaluation. For example, a provider

with an aberrant billing rate consistently just below the edit parameters is subject to intensified review. They develop procedures for FMR based on each of the following trends or characteristics:

- Edits with high charges per aggregate bill charges;
- Providers billing a higher than average utilization of specific diagnostic codes that fall just below the edit parameters; and
- Specific principal DX codes, such as those with longer visits and duration; those representing the most frequent denials in pre-pay MR; special codes, e.g., 585, Chronic Renal Failure; 733.1, Senile Osteoporosis; and 290.0-290.9, Senile and Presenile Organic Psychotic Conditions; and/or certain edit groups such as 17, 19, and 29 in one quarter and others in the next quarter.

7.6 - Outpatient OT Edits - (Rev. 3, 11-22-00)

The following edits do **not** represent normative (or average) treatment. It is prohibited to deny a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR.

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
1	Neoplasms:			
	Bone and articular cartilage	170.0-170.3	16	48
	Connective tissue	171.0-171.2		
	Female breast	174.0-174.9		
		198.81		
	Bone or breast, NOS	239.2-239.3		
	Brain and nervous system	191.0-192.9		
	Hodgkin's Disease	201.0-201.9		
	Multiple myeloma	203.0-203.8		
	Leukemia	204.0-208.9		
	Brain and spinal cord and nervous	237.5-237.9		
	System			
		170.4-170.5	24	62
	Bone and articular cartilage, upper limb	225.0-225.9		
	Brain and nervous system	239.6		
2	Schizophrenic disorder	295.30 thru	13	31
		295.45		
		295.80-295.95		
	Affective psychosis	296.00-296.99		
3	Parkinson's Disease	332.0-332.1	13	38
4	Meningitis/Encephalitis	320.0-323.9	16	62

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
	Intracranial and intraspinal abscess	324.0-324.9		
	Other extrapyramidal disease	333.0		
	Hydrocephalus and other cerebral	331.1-331.7		
	Degeneration	331.89		
	Huntington's Chorea and other	333.4-333.9		
	Choreas			
	Spinocerebellar disease	334.0-334.9		
	ALS and other motor neuron diseases	335.20-335.9		
	Other diseases of the spinal cord			
	Unspecified disorder of autonomic N.S.	336.0-336.9		
	Multiple Sclerosis	337.9		
	Demyelinating Diseases of CNS			
	Hemiplegia (old unspecified)	340		
	Other unspecified disorders of	341.8-341.9		
	Nervous system	342.0-342.9		
	Infantile cerebral palsy			
	Late effects of CVA	349.0-349.9		
	Other conditions of brain	343.0-343.9		
	Other ill defined cerebrovascular	438		
	Diseases	348.0-348.9		
	Intracranial injury	437.0-437.9		
		851.00-854.19		
5	Cerebral hemorrhage, occlusion,	430-434.9	28	72
	Stenosis CVA, acute	436		
	Concussion, Loss of consciousness	850.4		
	Without return to previous level			
	Intracranial injury including those	800.70-800.99		
	With skull Fx			
		801.70-801.99		
		803.20-803.49		
		803.70-803.99		
		804.70-804.99		
		800.30-800.49		
		801.49		
		804.20-804.49		
6	Other paralytic syndromes, paraplegia	344.0-344.9	32	93
	Quadriplegia			
7	Late effects polio	138	13	40
	Disorders of peripheral nerves	353.0-356.9	16	62
		357.1-359.9		
	Fx of vertebral column	806.00-806.5	30	93
	With spinal cord injury	806.8-806.9		
	Spinal cord injury without	952.00-953.1	24	62
	Spinal bone injury	953.4 & 953.8		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
	Peripheral nerve injury	955.0-955.9		
		957.0-957.9		
	Acute infective polyneuritis	357.0		
	Disturbance of skin	782.0	12	38
8	Diabetes with peripheral circulatory	250.00-250.01	16	2
	Disorders			
	Diseases of circulatory system	250.60-250.71	12	38
	Postmastectomy lymphedema	402.0-429.9	10	31
	Other lymphedema	457.0-457.1		
9	Chronic ulcer of skin	707.0-707.9	12	31
	Diabetes, ulcer (skin)	250.80-250.81		
	Cellulitis, finger	681.00-681.02		
	Open wounds	880.00-884.2		
	Burns (second degree)	941.20-941.29	18	62
		942.20-942.29		
		943.20-943.29		
		944.20-944.28		
		946.2 &		
		949.2		
10	Emphysema, asthma	492.0-493.91	8	31
	Chronic airway obstruction	496		
11	Chronic renal failure	585	12	38
	Acute renal failure	584.9		
	Nephritis, nephropathy	583.9		
	Renal failure unspecified	586		
12	Lupus erythematosus	695.4	16	62
	Diffuse disease of connective tissue	710.0-710.9		
	Arthropathy associated with infection	711.00-711.59		
	Rheumatoid arthritis and inflammatory	714.0-714.9		
	Palyarthropathies			
	Gouty arthopathy	274.0		
13	Ostearthrosis and allied disorders	715.00-716.99	13	31
14	Internal derangement of joint, other	718.00-718.99	16	48
	Derangement of joint and other			
	Unspecified disorders of joint			
15	Dorsopathies	720.0-722.0	13	31
		723.0		
		723.3-723.4		
		723.9		
	Osteitis deformans	731.0		
	Aseptic necrosis	733.40-733.41		
	Disorder of bone and cartilage	733.81-733.99		
	Other acquired deformities	738.8-738.9		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
		756.9		
	Other and unspecified anomalies of Musculo-skeletal system	730.00-730.29		
	Osteomyelitis	736.00-736.89		
	Acquired deformities	733.1	12	31
	Pathological Fx			
16	Peripheral enthesopathies and allied		13	31
	Syndromes	725-726.4		
	Disorders of muscles, tendons, their	726.8-727.05		
	Attachments and other soft tissues	727.2-727.50		
		727.59-727.64		
		727.69		
		727.81-728.6		
		728.81-729.2		
		729.39-729.9		
17	Senile dementia	290.0-290.9	10	31
	Other cerebral degenerations	331.0-331.2		
		331.9		
	Malaise, fatigue	780.7		
	Syncope/collapse convulsions,	780.2-780.4		
	Dizziness			
	Other symptoms involving nervous and Musculoskeletal system	781.9		
	Debility, unspecified	799.3		
	And other	799.8-799.9		
	Abnormal involuntary movements	781.0	12	38
	Incordination, transient paralysis	781.3-781.4		
	Of limb T.I.A.			
		435.0-435.9	13	38
18	Fx of vertebral column without cord	805.00-805.9	13	38
	Injury Fx of rib, sternum			
	Fx of clavicle	807.00-807.4	12	38
	Fx of unspecified bone	810.00-810.03		
		829.0-829.1		
19	Fx of pelvis	808.0-808.9	13	31
	Fx of femur	820.00-821.39		
20	Fx of scapula	811.00-811.19	13	31
	Fx of humerus, Fx of radius and ulna,	812.0-819.1	22	62
	Fx of carpals, Fx of metacarpals and			
	Phalanges			
21	Dislocations	831.00-834.12	18	62
	Crushing injury	927.00-927.9		
		929.0-929.9		
22	Sprains and strains	840.4-842.19	18	62
	Late effects of strains, sprains,	905.6-905.7	13	31

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
	Dislocations Contusions	923.3-923.9		
	Injury, other and unspecified	959.2-959.5		
23	Amputation upper lower	885.0-887.7	32	93
		897.0-897.7	12	38
24	Burns (3rd and 4th degree)	941.30-941.59	32	93
		942.30-942.55		
		942.59		
		943.30-943.56		
		943.49		
		944.30-944.58		
		946.3-946.5		
		949.3-949.5		
25	Joint replacement	V43.6	18	48
	Problem with limbs	V49.0-49.9	13	31
	Convalescence following Fx	V66.4		
	Follow-up exam FX	V67.4		
	Fitting and adjustment of prosthetic	V52.0		
	Device, Artificial arm Other orthopedic			
	Aftercare involving removal internal			
	Fixation device	V54.0	10	31
	Observation for specified suspected			
	Condition	V71.8		
	Orthopedic aftercare		12	38
	Other aftercare following surgery	V54.8-V54.9		
	Other specified aftercare	V58.4		
	Unspecified aftercare	V58.8		
	Other follow-up exam	V58.9		
	Late effects Fx spine and upper	V67.59, V67.9	13	38
	Extremities	905.1-905.2		
	Late effects tendon injury			
	Late effects traumatic amputation	905.8		
	Late effects of injuries	905.9		
	Complications of surgical and	906.0-909.9		
	Medical care	996.4		
		996.60-997.1		
		997.6-997.9		
		998.3 & 998.5		
		998.8-998.9		
		999.9		
26	Malnutrition (moderate) protein/calorie	263.0	13	38
	Abnormal weight loss	263.8-263.9		
	Feeding difficulties	783.2		
	Dysphagia	783.3		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
		787.2		

6 – Medical Review of Part B Intermediary Outpatient Speech-Language Pathology (SLP) Bills - (Rev. 3, 11-22-00)

Intermediaries use the following guidelines for review of SLP services. They base the review of SLP on effective focused review criteria. They implement the HCFA edits only if data supports their effectiveness in focusing review. These criteria do not apply to SLP services provided under a home health plan of care. The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits.

Intermediaries do not deny a bill solely on the basis that it exceeds the criteria in the edits. The edits are **only** for selecting bills to review or for paying bills without MR if they meet Level I criteria. Intermediaries must not provide automatic coverage up to these criteria. They neither guarantee minimum nor set maximum coverage limits.

6.1 - Level I Review - (Rev. 3, 11-22-00)

SLP edits have been developed for a number of diagnoses which were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with these diagnoses will require skilled SLP. The edits do not specify every diagnosis which may require SLP, and therefore, the fact that a given diagnosis does not appear in the edits does not create a presumption that SLP services are not necessary, or are inappropriate. Intermediaries do not approve or deny claims at Level I for medical necessity. They pay claims that pass the edits in Exhibit I and any additional edits approved by the RO without being subjected to Level II MR.

For patients receiving SLP services only (V57.3, Speech therapy) during an encounter/visit, the appropriate V code for the service is sequenced first, and, if documented, the diagnosis or problem for which the services are performed is sequenced second. The intermediary standard system must program the system to read the diagnosis or problem sequenced second to determine if it meets the Level I SLP edits.

Example: SLP services V57.3, for a patient with aphasia 784.3. The V code will be sequenced first, followed by the code for aphasia (V57.3, 784.3). Intermediaries edit for aphasia not the V code. They use this same procedure for V57.89, other specified rehabilitation procedure, and V57.9, unspecified rehabilitation procedure.

Providers submit the following documentation, and intermediaries evaluate bills at Level I based upon each of the following:

Facility and Patient Identification	Facility name, patient name, provider number, HICN, age
Diagnosis	The primary diagnosis for which SLP services were rendered must be listed by ICD-9-CM code first; other Dx(s) applicable to the patient or that influence care must follow.
Duration	The total elapsed time in days that SLP services have been rendered beginning with the date treatment was initiated by the billing provider for the diagnosis being treated (includes the last day in the current billing period).
Number of Visits	The total number of visits completed since SLP services were initiated by the billing provider for the diagnosis being treated. Include the last visit in the billing period in the total visits to date. **Do not obtain only the visits for this month's billing period.** (Value code 52).
Date Treatment Started (Occurrence Code 45)	The date SLP services were initiated by the billing provider for the speech, language and related disorder.
Billing Period	When SLP services began and ended in the billing period (from/through dates).

6.2 - Level II Review - (Rev. 3, 11-22-00)

If a bill meets the intermediary's focused MR criteria, they refer it to the Level II MR health professional staff. If possible, they have a speech-language pathologists review SLP bills. Once the bill is selected for focused MR, they review the data in conjunction with medical information submitted by the provider.

A. Payable SLP Services

Intermediaries pay SLP services only if they meet applicable Medicare coverage requirements. Each bill for SLP services that is subjected to Level II MR must be supported with adequate medical documentation to make a determination. (See MIM §§3101 and 3148.)

6.3 - MR Documentation - (Rev. 3, 11-22-00)

When a claim is referred to Level II MR, intermediaries use the following pertinent data elements in addition to those used for Level I review:

Medical History	Intermediaries obtain only the medical history which is pertinent to, or influences the SLP treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring SLP, and any pertinent prior SLP treatment.
Speech, Language, and Related Disorder	The diagnosis or diagnoses established by the speech-language pathologist. Examples are spoken language production disorder (expressive aphasia), dysarthria, and dysphagia.
Date of Onset (Occurrence Code 11)	The date of onset or exacerbation of the speech, language and related disorder diagnosis for which services were rendered by the billing provider.
Physician Referral and Date Received by the Billing Provider	Self-explanatory
Initial Assessment and Date	The procedure used by the speech-language pathologist to diagnose speech, language, and related disorders, and the date the initial assessment is completed by the billing provider.
Plan of Treatment and Date Established	Self-explanatory
Date of Last Certification	Intermediaries obtain the date on that the plan of treatment was last certified by the physician.
Progress Notes	Intermediaries obtain updated patient status reports concerning the patient's current functional communication abilities/limitation.

6.3.1 - Medical History - (Rev. 3, 11-22-00)

If a history of previous SLP treatment is not available, the provider may furnish a general summary regarding the patient's past relevant medical history recorded during the initial assessment with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior treatment for the current condition, progress made, and treatment by the referring physician must be provided when available. The level of function prior to the current exacerbation or onset should be described.

The patient's medical history includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.
The history of treatments from a previous provider is necessary for patients who have transferred to a new provider for additional treatment. For chronic conditions, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled care.

6.3.2 - Assessment - (Rev. 3, 11-22-00)

Intermediaries approve the initial assessment when it is reasonable and necessary for the speech-language pathologist to determine if there is an expectation that either restorative services or establishment of a maintenance program will be appropriate for the patient's condition.

Reassessments are covered if the patient exhibits a demonstrable change in motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated SLP services. Periodic routine reevaluations (e.g., monthly, bimonthly) for a patient undergoing a SLP program are part of the treatment session and are not covered as separate evaluations. An initial assessment or reassessment that is determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the assessment determines that skilled services are not needed.

The assessment establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals. The initial assessment must include objective baseline diagnostic testing (standardized or non-standardized), interpretation of test results, and clinical findings. If baseline testing cannot be accomplished for any reason, note this in the initial assessment or progress notes, along with the reason(s). Include a statement of the patient's expected rehabilitation potential.

6.3.3 - Plan of Treatment - (Rev. 3, 11-22-00)

The plan of treatment must contain the following:

- Type and nature of care to be provided;
- Functional goals and estimated rehabilitation potential;
- Treatment objectives;
- Frequency of visits; and
- Estimated duration of treatment.

A. Functional Goals

Functional goals must be written by the speech-language pathologist to reflect the level of communicative independence the patient is **expected** to achieve outside of the therapeutic environment. The functional goals reflect the final level the patient is expected to achieve, are realistic, and have a positive effect on the quality of the patient's everyday functions. Intermediaries assume that certain factors may change or influence the final level of achievement. If this occurs, the speech-language pathologist must document the factors which led to the change of the functional goal. Examples of functional communication goals in achieving optimum communication independence are the ability to:

- Communicate basic physical needs and emotional status;
- Communicate personal self-care needs;
- Engage in social communicative interaction with immediate family or friends; or
- Carry out communicative interactions in the community.

NOTE: The term "communication" includes speech, language, as well as voice skills.

A functional goal may reflect a small, but meaningful change that enables the patient to function more independently in a reasonable amount of time. For some patients, it may be the ability to give a consistent "yes" and "no" response; for others, it may be the ability to demonstrate a competency in naming objects using auditory/verbal cues. Others may receptively and expressively use a basic spoken vocabulary and/or short phases, and still others may regain conversational language skills.

B. Treatment Objectives

Treatment objectives are specific steps designed to reach a functional goal. When the patient achieves these objectives, the functional goal is met.

C. Frequency of Visits

Frequency of visits is an estimate of how often the treatments are to be rendered (e.g., 3x week).

Length of visits are typically 30, 45, or 60 minutes. Sometimes patients are seen for shorter periods several times a day (e.g., three 10 minute sessions, or a total of 30 minutes). Rarely, except during an assessment, are sessions longer than 60 minutes. If so, the provider must justify them, by noting, for example, that the patient is exceptionally alert, the number of appropriate activities needing skilled intervention is greater than average, special staff/family training is required. Post-operative intensive treatment is sometimes required (e.g., tracheoesophageal puncture) or post-onset of disorder (due to intensive family involvement).

D. Estimated Duration of Treatment

Estimated duration of treatment refers to the total estimated time over which the services are to be rendered, and may be expressed in days, weeks, or months.

6.3.4 - Progress Reports - (Rev. 3, 11-22-00)

Intermediaries obtain progress reports or treatment summary for the billing period including:

- The initial functional communication level of the patient at this provider setting;
- The present functional level of the patient and progress (or lack of progress) specific for this reporting period;
- The patient's expected rehabilitation potential; and
- Changes in the plan of treatment.

Where a valid expectation of improvement existed at the time services were initiated, or thereafter, the services are covered even though the expectation may not be realized. However, in such instances, intermediaries approve the services up to the time that no further significant practical improvement can be expected. Progress reports must document a continued expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of communication, independence, and competence compared to their levels when treatment was initiated. Intermediaries must not interpret the term "significant" so stringently that they may deny a claim because of a temporary setback in the patient's progress. For

example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's overall functional ability will occur. However, the speech-language pathologist and/or physician should document such lack of progress and explain the need for continued intervention.

Documentation includes a short narrative progress report and objective information in a clear, concise manner. This provides the reviewer with the status on progress in meeting the plan of treatment, along with any changes in the goals or the treatment plan. Medical reviewers request that new plans be forwarded with the original so that they can review the entire plan. However, the reviewer must have access to an overall treatment plan with final goals and enough objective information with each claim to determine progress toward meeting the goals.

Consistent reporting is important. For example, if the provider reports that the patient can produce an "m" 25 percent of the time, then reports 40, 60, 90 percent success, the intermediary may believe that treatment might be ending. However, if they have the final goal and the objectives, they can see the progress toward that goal and the steps needed to reach it. The speech-language pathologist might state that the final goal is "the ability to converse in a limited environment."

One underlying SLP goal might be to "reduce the apraxia sufficiently so the patient can initiate short intelligible phrases with a minimum of errors." Short-term goals may include the patient's ability to initiate easier phonemes before other, more difficult, phonemes. Therefore, the speech-language pathologist has a linguistically and neurologically sound basis for working on one phoneme production before initiating another.

The speech-language pathologist might work on a group of phonemes having a "feature" in common before working on another group. For example, working on all bilabials (since the patient can easily see the movement), might be desirable prior to sounds that are produced more intraorally.

The speech-language pathologist may choose how to demonstrate progress. However, the method chosen, as well as the measures used, generally remain the same for the duration of treatment. The provider must interpret reports of test scores, or comparable measures and their relationship to functional goals in progress notes or reports. Diagnostic testing should be appropriate to the communication disorder.

While a patient is receiving SLP treatment, the speech-language pathologist reassesses the patient's condition and adjusts the treatment. However, if the method used to document progress is changed, the reasons must be documented, including how the new method relates to the previous method. If the speech-language pathologist reports a sub-test score for one month,

then a score of a different sub-test the next month without demonstrating the sub-test's interrelationship, you are not able to judge the progress. The intermediary should return these claims for an explanation/interpretation. They may refer the claims to Level III MR if needed.

6.3.5 -Level of Complexity of Treatment - (Rev. 3, 11-22-00)

Intermediaries must base decisions on the level of complexity of the services rendered by the speech-language pathologist, not what the patient is asked to do. For example, the patient may be asked to repeat a word and the speech-language pathologist analyzes the response and gives the patient feedback that the patient uses to modify the response. The speech-language pathologist may ask staff or family to repeat the activity as a reinforcement. It is the speech-language pathologist's analysis that makes the activity skilled.

6.3.6 - Reporting on New Episode or Condition - (Rev. 3, 11-22-00)

Occasionally, a patient who is receiving, or has previously received SLP services, experiences a secondary or complicating new illness. The provider documents the significance of any change to the communication capabilities. This may be by pre-and post-episodic objective documentation, through nursing notes or by physician reports. If the patient is receiving treatment, it might have to be lengthened because of his change in condition. If the patient has completed treatment, a significant change in the communication status must be documented to warrant a new treatment plan.

6.3.7 - Certification and Re-certification - (Rev. 3, 11-22-00)

SLP services must be certified and re-certified by a physician and furnished while under the care of a physician. They must be furnished under a written plan of treatment established by the physician or a qualified speech-language pathologist providing such services. If the plan is established by a speech-language pathologist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When outpatient SLP services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days that there is a continuing need for them. Intermediaries obtain the re-certification when reviewing the plan of treatment since the same interval of at least 30 days is required for the review of the plans. Re-certification must be signed by the physician who reviewed the plan of treatment. Any changes established by the speech-language pathologist must be in writing and signed by the speech-language pathologist or by the attending physician. The physician may change a plan of treatment established by the speech-language pathologist. The speech-language pathologist may not alter a plan of treatment established by a physician.

6.4 - Qualified Speech-Language Pathologist - (Rev. 3, 11-22-00)

The following information is provided to familiarize the intermediary staff with Medicare requirements for qualifications of speech-language pathologists and specific acronyms commonly used. A qualified speech-language pathologist meets the following criteria:

- A person who is licensed, if applicable, by the State in which he/she is practicing; and
- Is eligible for a certificate of clinical competence in SLP 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.

A qualified speech-language pathologist normally indicates certification status by utilizing CCC-SLP or CFY-SLP. A CCC-SLP is a Certificate of Clinical Competence in SLP and a CFY-SLP is a Clinical Fellowship Year in Speech-Language Pathology.

6.5 - Skilled and Unskilled Procedures - (Rev. 3, 11-22-00)

Certain services are skilled or non-skilled by definition. However, for coverage, the services must be reasonable and necessary based on the MR of the documentation submitted. The following are examples of specific types of skilled and nonskilled SLP procedures.

A. Skilled Procedures. Skilled procedures include:

- Diagnostic and assessment services to ascertain the type, causal factor(s) and severity of speech and language disorders. Reassessment is needed if the patient exhibits a change in functional speech or motivation, clearing of confusion, or remission of some other medical condition which previously contraindicated SLP or audiology services.
- Design of a treatment program relevant to the patient's disorder(s). Continued assessment of progress during the implementation of the treatment program, including documentation and professional analysis of the patient's status at regular intervals.
- Establishment of compensatory skills (e.g., air-injection techniques, word finding strategies).
- Establishment of a hierarchy of speech-language tasks and cueing that directs a patient toward communication goals.
- Analysis related to actual progress toward goals.

- Patient and family training to augment restorative treatment or to establish a maintenance program.

B. Unskilled Procedures. The following are considered unskilled procedures:

- Non-diagnostic/non-therapeutic routine, repetitive and reinforced procedures (e.g., the practicing of word drills without skilled feedback).
- Procedures which are repetitive and/or that reinforce previously learned material which the patient or family is instructed to repeat.
- Procedures which may be effectively carried out with the patient by any nonprofessional (e.g., family member, restorative nursing aide) after instruction and training is completed.
- Provision of practice for use of augmentative or alternative assessment communication systems.

NOTE: It is only after the patient has established a high level of consistency of performance in a task with the speech-language pathologist that unskilled techniques can be implemented.

6.5.1 - Statements Supporting and Not Supporting Coverage - (Rev. 3, 11-22-00)

This is documentation which is objective or subjective and demonstrates whether there is progress toward a stated functional goal.

A. Statements Supporting Coverage

Typically, these statements have an objective component which is compared to previous reports, and which demonstrate progress toward a stated functional goal.

Examples: "Mr. Smith achieved 75 on the Word Subtest on the Johnson Test of Aphasia compared with last month's score of 50 on the same Subtest."

"Mr. Jones achieved a combined score of 352 on the A, B, C, D, and E subtests this month compared with an overall score of 250 for these same subtests last month."

"Mrs. Jones achieved the next steps in the treatment plan outlined last month (see attached sheet). If she continues at this rate, she should complete treatment within the next 2 months."

"Mrs. Jones achieved 75% (7.5 out of 10 or 75 out of 100) on word naming which compares to last month's score of 50% (5.0 out of 10 or 50 out of 100)."

NOTE: Percentages should be based on real number count. **Interpretation of scores must be presented in progress notes or summary information.** The narrative should also contain reference to objective scoring, comparison of previous scores, or treatment plan with present status compared to previous status. This information may be embedded in narrative or attached, however, the reviewer should have access to this information and **stated functional goals.**

B. Statements That Do Not Support Coverage

Typically, statements that do not support coverage are subjective, and do not demonstrate progress toward a stated functional goal, or a comparison to previous test scores.

Examples: "Ms. Jones is very concerned about going home. She has begun smoking again which is causing family as well as physical problems."

"Speech somewhat slurred today."

"Mr. Smith more consistent in responses."

"Mr. Jones has shown significant improvement in his ability to make himself understood."

"Patient is now able to inject air 80% of the time." (No comparison to previous report.)

"Mrs. Smith achieved 75% accuracy on word naming task. (No comparison to previous report)."

"Auditory comprehension improved from moderately impaired to mildly impaired." (By itself, the statement does not offer sufficient objective information.)

C. Resumption of Treatment

There are conditions and circumstances that justify resuming treatment after it has been delayed. Intermediaries obtain verification (when needed for coverage decisions). Examples include:

- Patient becomes more alert, attentive, cooperative;
- Patient shows rehabilitation potential;

- Medical complications cleared;
- Environmental change improves motivation or communicative capabilities;
- Progressive nature of disorder warrants further treatment; and
- Drug or other medical treatment is reduced or ended.

6.5.2 - MR Considerations - (Rev. 3, 11-22-00)

A. Disorders Typically Not Covered for the Geriatric Patient

- Stuttering (except neurogenic stuttering caused by brain damage);
- Fluency Disorder;
- Cluttering;
- Disprosody;
- Disfluency;
- Myofunctional Disorders;
- Tongue Thrust; and
- Behavioral/Psychological Speech Delay.

B. Maintenance Program

Intermediaries approve claims only when the specialized knowledge and judgment of a qualified speech-language pathologist is required to design and establish a maintenance program. By the time the patient's restorative program has been completed, the maintenance program has already been designed, with instructions to the patient, supportive personnel, or family. They do not approve a separate charge for establishing the maintenance program immediately after the restorative program has been completed.

Intermediaries obtain documentation that justifies a provider reestablishing a maintenance program, e.g., loss in previous functional abilities occurs, intervening medical conditions develop, difficulty in communicating with care-givers arises.

The initial assessment should be documented with standardized testing (if possible) to establish base-line data. This is critical if a claim is submitted for care at a future date. Documentation should show that the maintenance program is designed by the speech-language pathologist

appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician.

The maintenance program is established when documentation indicates it has been designed for the patient's level of function and instructions to the patient and supportive personnel have been completed for them to safely and effectively carry them out. The documentation must give reasonable assurances that this has occurred. After that point, the services are not reasonable and necessary.

C. Group Treatment

Generally, group therapy treatment and attendance at social or support groups, such as stroke clubs or lost cord clubs, are not payable. Intermediaries ensure that the "reasonable and necessary" requirements are met.

D. Total Laryngectomy

Total laryngectomy is surgical removal of the larynx. Documentation may involve pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about alternative communication methods, and to provide an immediate means of communication. Documentation includes assessment and any treatment necessary to establish a means of communication using esophageal speech, an artificial larynx (electronic or pneumatic device), a tracheoesophageal puncture prosthesis, and/or other alternate communication methods.

E. Partial Laryngectomy

A partial laryngectomy is the surgical removal of part of the larynx. Documentation includes the voice problems that require assessment and treatment. Documentation may involve pre-op/post-op sessions as part of the assessment, and to inform the patient, the family, and staff about voice problems. Documentation for rehabilitation includes the assessment and type of treatment required for the voice disorders, as well as base-line objective data and progress notes.

F. Total Glossectomy

A total glossectomy is the surgical removal of the tongue. Total glossectomy results in articulation problems that require assessment and may require treatment. Documentation may include pre-op/post-op sessions as part of the assessment to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication and/or to establish an effective maintenance program. Documentation includes assessment and type of

treatment for the articulation disorders. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

G. Partial Glossectomy

A partial glossectomy is the surgical removal of part of the tongue. Documentation should indicate the articulation problems that require assessment and treatment. Documentation may include pre-op/post-op sessions as part of the assessment to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication following surgery. Documentation includes the assessment and type of treatment for the articulation disorders including base-line objective data and progress notes. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

H. Congenital Disorders

Documentation for congenital disorders must always substantiate need, e.g., no previous treatment; the patient's communicative capabilities have recently deteriorated; new, special techniques or instruments have become available; or intervening medical complications have affected SLP communication. Intermediaries approve claims for maintenance or short-term treatment only if objective documentation supports that need.

I. Alzheimer's Disease (chronic brain syndrome, organic brain syndrome)

Objective documentation must indicate the patient's condition, alertness and mental awareness. Documentation must justify that services are needed to establish a reasonable and necessary maintenance program. Review these claims carefully for medical necessity.

J. Chronic Conditions

Intermediaries approve claims for patients with chronic conditions such as MS, ALS, Parkinson's Disease or Myasthenia Gravis if they document a need for reasonable and necessary short-term care or a need to establish a maintenance program. However, clear documentation must be present concerning any prior care or maintenance program designed for the same condition. They approve claims for reasonable and necessary short-term intervention to improve oral and laryngeal strength, speech intelligibility, or vocal intensity, but only when the documentation supports the need to increase function, or to establish a maintenance program.

6.5.3 - FMR Evaluation - (Rev. 3, 11-22-00)

The HCFA edits will aid in identifying SLP claims for FMR. Intermediaries perform regular evaluations of provider claims which pass or fail the edits. Intermediaries must change the focused review selection based on the results of the evaluation. For example, a provider billing at an aberrant rate consistently, just below the parameters is to be subjected to focused review.

Intermediaries must be on the alert for any of the following trends or characteristics in developing focused MR:

- Edits with high charges per aggregate bill charges;
- Providers billing a higher than average utilization of specific diagnostic codes that fall just below the edit parameters; or
- Specific principal DX codes, such as those with longer visits and duration, those representing the most frequent denials in pre-pay MR, special codes, and/or certain edit groups such as 1, 3, 5 and 8 in one quarter, and others in the next quarter.

6.5.4 - SLP Terms - (Rev. 3, 11-22-00)

A. Agnosia

Agnosia is the inability to attach meaning to sensory information although the physiologic receptor mechanism is intact.

B. Agrammatism

Agrammatism is the impairment of the ability to produce words in their correct sequence; difficulty with grammar and syntax.

C. Agraphia

Agraphia is a disorder of writing. It may result from a central nervous system lesion or from lack of muscular coordination.

D. Anomia

Anomia is loss of the ability to identify or to recall and recognize names of persons, places or things.

E. Aphasia

Aphasia is a communication disorder caused by brain damage and characterized by complete or partial impairment of language comprehension, formulation, and use. It excludes disorders associated with primary sensory deficits, general mental deterioration, or psychiatric disorders. Partial impairment is often referred to as dysphasia.

F. Aphonia

Aphonia is loss of voice.

G. Apraxia

Apraxia is:

- Disruption in the ability to transmit a motor response along a specific modality; involves disruption of voluntary or purposeful programming of muscular movements while involuntary movements remain intact; characterized by difficulty in articulation of speech, formulation of letters in writing, or in movements of gesture and pantomime.
- In speech, a nonlinguistic sensorimotor disorder of articulation characterized by impaired capacity to program the position of speech musculature and the sequencing of muscle movements (respiratory, laryngeal, and oral) for the volitional production of phonemes.

H. Dysarthria

Dysarthria is the term for a collection of motor speech disorders due to impairment originating in the central or peripheral nervous system. Respiration, articulation, phonation, resonation, and/or prosody may be affected; volitional and automatic actions, such as chewing and swallowing, and movements of the jaw and tongue may also be deviant. It excludes apraxia and functional or central language disorders.

I. Dysphagia

Dysphagia is difficulty in swallowing. It may include inflammation, compression, paralysis, weakness, or hypertonicity of the esophagus.

J. Generalization

Generalization is:

- In conditioning, the eliciting of a conditioned response by stimuli similar to a particular conditioned stimulus.
- Transfer of learning from one environment to a similar environment; the more similar the environments or situations, the greater transfer takes place.

K. Hard Glottal Attack

A hard glottal attack is forceful approximation of the vocal folds during the initiation of phonation.

L. Intonation

Intonation is the linguistic system within a language which is concerned with pitch, stress, and juncture of the spoken language; a unit with specific communicative import, such as interrogation, exclamation, and assertion.

M. Lexicon

Lexicon is total accumulation of linguistic signs, words or morphemes, or both, in a given language; the list of all the words in a language.

N. Morphology

Morphology is a component of grammar concerned with the formation of words, the smallest meaningful unit in a language, as a bridge between phonology and syntax.

O. Obturator

Obturator is (l) Any structure which occludes an opening. (2) Prosthetic appliance, similar to a dental plate, that forms an artificial palate to cover a cleft palate, designed so that the musculature of the palate and pharynx are able to contract around it.

P. Paraphasia

Paraphasia is any error of commission modifying a specific word (sound and morpheme substitution) or of word substitution in the spoken or written production of a speaker or writer.

Q. Perseveration

Perseveration is the tendency to continue an activity, motor or mental, once started, and to be unable to modify or stop even though it is acknowledged to have become inappropriate.

R. Phoneme

Phoneme is the shortest arbitrary unit of sound in a given language that can be recognized as being distinct from other sounds in the language.

S. Phonological

Phonological is a component of grammar determining the meaningful combination of sounds.

T. Pitch

Pitch is acuteness or gravity of a tone, dependent upon the frequency of the vibrations producing it and their intensity and overtone structure. The greater the number of vibrations per unit of time, the higher the pitch and the more acute the tone.

U. Pragmatics

Pragmatics is the functional use of language in context. It includes such factors as intention in communication; sensorimotor actions preceding, accompanying, and following the utterance; knowledge shared in the communicative dyad; and the elements in the environment surrounding the message.

V. Prosody

Prosody is:

- Physical attributes of speech that signal linguistic qualities such as stress and intonation. It includes the fundamental frequency intensity of the voice, and the duration of the individual speech sounds.
- A melody of speech determined primarily by modifications of pitch, quality, strength, and duration; perceived primarily as stress and intonational patterns.

W. Psychoacoustics

Psychoacoustics is the combined disciplines of psychology and acoustics concerned with the study of man's response to sound.

X. Semantic

Semantic is a component of grammar concerned with word meanings and meaningful sentences.

Y. Sntactic

Syntactic is a component of grammar concerned with grammatically well formed structures.

6.5.5 - Acronyms and Abbreviations - (Rev. 3, 11-22-00)

ADL - Activities of Daily Living.
ALPS - Aphasia Language Performance Scales.
ASHA - American-Speech-Language-Hearing Association.
ASL - American Sign Language.
CVC - Consonant-vowel-consonant.
CPS - Cycles per second. Former unit of measurement for the number of successive compressions and rarefactions of a sound wave within one second of time, now replaced with Hertz (Hz).
Dx - Diagnostic therapy.
MLU - Mean Length of Utterance - Average length of oral expressions as measured by a representative sampling of oral language. It is usually obtained by counting the number of morphemes per utterance and dividing by the number of utterances.
VOT - Voice Onset Time - (1) Time between the release of the stop consonant and the beginning of voicing in the vowel. (2) Time required to initiate sound at the vocal folds.

6.5.6 - SLP Tests - (Rev. 3, 11-22-00)

These tests include but are not limited to:

A. Widely Used Adult Language Tests

- Ammons Full Range Picture Vocabulary Test;
- Aphasia Clinical Battery I;
- Aphasia Language Performance Scales (ALPS);
- Appraisal of Language Disturbances (ALD);
- Boston Diagnostic Aphasia Examination (BDAE);
- Communicative Abilities in Daily Living (CADL);
- Examining for Aphasia;

- Functional Communication Profile;
- International Test for Aphasia;
- Language Modalities Test for Aphasia;
- Language Proficiency Test (LPT);
- Minnesota Test for Differential Diagnosis of Aphasia;
- Porch Index of Communicative Abilities (PICA);
- Revised Token Test;
- Sklar Aphasia Scale;
- Token Test for Receptive Disturbances in Aphasia;
- Hodson Phonological Process Analysis;
- Clinical Evaluation of Language Functions (CELF);
- Western Aphasia Battery.

B. Widely Used Adult Articulation Tests

- Apraxia Battery for Adults (ABA);
- Assessment of Intelligibility of Dysarthric Speech;
- Compton-Hutton Phonological Assessment;
- Frenchay Dysarthria Test;
- The Fisher-Logemann Test of Articulation Competence;
- Iowa Pressure Articulation Test;
- Templin Darley Test of Articulation.

C. Speech and Language Diagnostic Tests

Speech and language diagnostic tests are an initial assessment (including diagnostic testing, if clinically possible) must be performed prior to the commencement of treatment. If the reviewer needs assistance in understanding tests used, consult the speech language pathologist consultant or the American Speech, Language, Hearing Association.

6.6 - Outpatient SLP Edits - (Rev. 3, 11-22-00)

Outpatient SLP edits do not represent normative (or average) treatment. Intermediaries do not deny a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR.

Outpatient Medical Review

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
1	**Malignant Neoplasms**			
	Lip	140.0-140.9	28	93
	Tongue	141.0-141.9		
	Salivary glands	142.0-142.9		
	Gum	143.0-143.9		
	Mouth, floor, and other unspecified parts	144.0-145.9		
	Oropharynx	146.0-146.9		
	Nasopharynx and hypopharynx and other ill defined sites.	147.0-149.9		
	Esophagus cervical	150.0		
	upper third	150.3		
	Larynx	161.0-161.9		
	Brain	191.0-191.9		
	Other and unspecified parts of nervous	192.0-192.1		
	system	192.8-192.9		
	Head, face, neck	195.0		
	Brain & spinal cord	198.3		
	meninges	198.4		
2	**Benign Neoplasms**:			
	Lip, oral cavity and pharynx	210.0-210.9	28	93
	Head, face, neck	215.0		
	Brain and other part nervous	225.0-225.2		
	system	225.8-225.9		
	Carcinoma in situ of lip, oral cavity pharynx	230.0		
	Larynx	231.0		
	Uncertain behavior: salivary glands	235.0		
	Lip oral cavity/pharynx	235.1		
	Larynx	235.6		
	Brain and spinal cord	237.5		
	Meninges	237.6		
	Other and unspecified parts of nervous	237.9		
	system			
	Unspecified nature, brain	239.6		
	Unspecified nature, site unspecified	239.9		
3	**Nutrition/Dysphagia:**			
	Dysphagia	787.2	13	38
	Feeding difficulties	783.3		
	Problems with swallowing and mastication	V41.6		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
4	Developmental/Other Anomalies:			
	Developmental speech or language disorder	315.31-315.9	0	0
	Mental retardation	317-319		
	Cleft palate	749.00-749.04		
	Cleft palate with cleft lip	749.20-749.25		
	Cerebral palsy	343.0-343.9		
5	Central Nervous Systems:			
	Meningitis/Encephalitis	320.0-323.9	28	93
	Intracranial abscess or unspecified site	324.0, 324.9		
	Late effects intracranial abscess or pyogenic infection	326		
	Cerebral degeneration, Alzheimer's	331.0	0	0
	Disease (excludes senility)	331.2		
	hydrocephalus & other	331.3-331.9		
	Parkinson’s disease	332.0-332.1	12	62
	Other degnerative disease of basal ganglia	333.0-333.2		
	Huntington’s chorea/other	333.4-333.5		
	Dystonias	333.6-33.7		
	Orofacial dyskinesia	333.82		
	Spinocerebellar disease	334.0-334.9		
	Motor neuron disease	335.20-335.29		
	Multiple sclerosis	340		
	Other demyelinating diseases of CNS	341.0-341.9		
6	Central Nervous System			
	Specified/unspecified paralysis	334.8-344.9	6	21
	Other conditions of brain and nervous	348.1-348.9		
	system	3491.-349.9		
	Transient cerebral ischemia	435.0-435.9		
	Other and ill defined cerebrovascular disease	437.0-437.9		
	Late effects CVA	438		
7	Cranial/Peripheral Nerves			
	Trigeminal	350.1-350.9	12	62
	Facial	351.0-351.9		
	Glossopharyngeal	352.1-352.2		
	Mononeuritis unspec.	355.9		
	Idiopathic/unspec.	356.8-356.9		
	Myasthenia gravis	358.0		
	Myoneural disorders	385.2-358.9		
	Myotonic/myopathy disorders	359.2-359.4		

Outpatient Medical Review

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
8	**Cerebrovascular Disease:**			
	Hemiplegia	342.0-342.9	29	108
	Cerebral hemorrhage	430-432.9		
	Occlusion/stenosis	433.0-434.9		
	Acute CVA	436		
	Arterial embolism/thrombosis (unspec.)	444.9		
	Injuries to multiple blood vessels of head			
	And neck	900.82		
	Aphasia	784.3		
9	**Respiratory Laryngeal System:**			
	Chronic Laryngitis and	476.0-4761	12	62
	laryngotracheitis			
	Other diseases of pharynx, not elsewhere	478.20-478.29		
	classified			
	Polyp of vocal cord or larynx	478.4		
	Other disease of vocal cords	478.5		
	Edema of larynx	478.6		
	Other diseases of larynx, not elsewhere	478.70-478.79		
	Classified	786.09		
	Other symptoms involving respiratory system	478.31-478.34	12	93
	Paralysis of vocal cords or larynx			
10	**Voice/Speech Communication:**			
	Voice disturbance	784.40-784.49	12	63
	Other speech disturbance	784.5		
	Other symbolic dysfunction	784.69	28	93
11	**Intracranial Injury:**			
	Concussion	850.2-850.9	20	93
	Cerebral laceration and contusion	851.00-851.99	29	108
	Cerebral hemorrhage	852.00-853.19		
	Intracranial injury	854.00-854.19		
12	**Injury Head Mouth/Neck**			
	Complicated:			
	Fracture Larynx/trachea	807.5-807.6	12	70
	Mouth/tongue/palate	873.70-873.72		

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (Days)
		873.74-873.79		
	Larynx	874.10-874.11		
	Pharynx			
	Injury to multiple blood vessels of head	874.5		
	and neck	900.82		
13	Late Effects of Injuries/Other:			
	Skull and face	905.0	6	31
	Nervous system	907.0-907.1		
	Blood vessel head, neck	908.3		
	Crushing injury face	925		
	Unspecified injuries, Face/neck	959.0		
	Unspecified site	959.9		
	Complications due to unspecified device implant and graft	996.70		
	CNS complications	997.0		
	Unspecified complications	998.9, 999.9		
14	V Codes:			
	History of malignant neoplasm larynx	V10.21	1	1
	brain	V10.85		
	Problem with communication (including	V40.1	2	14
	speech)			
	Problems with hearing	V41.2		
	Problem with voice production	V41.4		
	Organ or tissue replaced (Larynx)	V43.8	1	1
	*Speech–language pathology	V57.3*		
	other	V57.89*		
	unspecified	V57.9*		
	Other aftercare following surgery	V58.4		
	Other specified after-care	V58.8		
	Follow-up exam/surgery	V67.0		
	Following other treatment (other)	V67.59		
	Observation for other specified suspected conditions	V71.8		
	Other specified examination	V72.8		

*These codes should be sequenced 1st. The medical diagnosis for which SLP is rendered is sequenced 2nd. For example, a speech encounter for acute CVA would be coded V57.3, 436. The intermediary standard system must be programmed to read the 2nd listed code (CVA-436).

10 - Special Instructions for MR of Dysphagia Claims - (Rev. 3, 11-22-00)

Intermediaries must follow the procedures described below for medical review of dysphagia claims for SLP, OT, and PT services.

A. Medical Work-up

Documentation by the physician must establish a preliminary diagnosis and form the basis of estimates of progress. Patients must be selected for therapy after a proper medical diagnostic evaluation by a physician. The medical work-ups must document whether the difficulty involves the oral, pharyngeal, or esophageal phase of swallowing. This may involve collaboration with therapists or speech-language pathologists.

B. Dysphagia Criteria - Oral, Pharyngeal, or Esophageal (upper one third) Phase of Swallowing

Documentation must indicate the patient's level of alertness, motivation, cognition, and deglutition. In addition, at least one of the following conditions must be present:

- History of aspiration problems or aspiration pneumonia, or definite risk for aspiration, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia;
- Nasal regurgitation, choking, frequent coughing up food during swallowing, wet or gurgling voice quality after swallowing liquids or delayed or slow swallow reflex;
- Presence of oral motor disorders such as drooling, oral food retention, leakage of food or liquids placed into the mouth;
- Impaired salivary gland performance and/or presence of local structural lesions in the pharynx resulting in marked oropharyngeal swallowing difficulties;
- In-coordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the buccal cavity and/or bite, chew, suck, shape and squeeze the food bolus into the upper esophagus while protecting the airway;
- Post-surgical reaction affecting ability to adequately use oropharyngeal structures used in swallowing;
- Significant weight loss directly related to non-oral nutritional intake (g-tube feeding) and reaction to textures and consistencies; or
- Existence of other conditions such as presence of tracheostomy tube, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, laryngeal closure, or pharyngeal peristalsis, and cricopharyngeal dysfunction.

C. Esophageal (lower two thirds) Phase of Swallow

Esophageal dysphagia (lower two thirds of the esophagus) is difficulty in passing food from the esophagus to the stomach. If peristalsis is inefficient, patients may complain of food getting stuck or of having more difficulty swallowing solids than liquids. Sometimes patients experience esophageal reflux or regurgitation if they lie down too soon after meals.

Inefficient functioning of the esophagus during the esophageal phase of swallowing is a common problem in the geriatric patient. Swallowing disorders occurring only in the lower two thirds of the esophageal stage of the swallow have not generally been shown to be amenable to swallowing therapy techniques and may not be approved. An exception might be when discomfort from reflux results in food refusal. A therapeutic feeding program in conjunction with medical management may be indicated and constitute reasonable and necessary care. A reasonable and necessary assessment of function, prior to a conclusion that difficulties exist in the lower two thirds of the esophageal phase, may be approved, even when the assessment determines that skilled intervention is not appropriate.

D. Assessment

Medical work-up and professional assessments must document history, current eating status, and clinical observations such as:

- Presence of a feeding tube;
- Paralysis;
- Coughing or choking;
- Oral motor structure and function;
- Oral sensitivity;
- Muscle tone;
- Cognition;
- Positioning;
- Laryngeal function;
- Oropharyngeal reflexes; and
- Swallowing function.

This information is used to determine necessity for further medical testing, e.g., videofluoroscopy, upper GI series, endoscopy. If videofluroscopic assessment is conducted (modified barium swallow), documentation must establish that the exact diagnosis of the swallowing disorder cannot be substantiated through oral exam and there is a question as to whether aspiration is occurring. The videofluoroscopy assessment is conducted and interpreted by a radiologist with assistance and input from the physician and/or individual disciplines. The assessment and final analysis and interpretation should include a definitive diagnosis, identification of the swallowing phase(s) affected, and a recommended treatment plan. An analysis by an individual discipline may be submitted as a separate line item charge.

E. Care Planning

Documentation must delineate goals and type of care planned which specifically addresses each problem identified in the assessment, such as:

- Patient care-giver training in feeding and swallowing techniques;
- Proper head and body positioning;
- Amount of intake per swallow;
- Appropriate diet;
- Means of facilitating the swallow;
- Feeding techniques and need for self help eating/feeding devices;
- Food consistencies (texture and size);
- Facilitation of more normal tone or oral facilitation techniques;
- Oromotor motor and neuromuscular facilitation exercises to improve or motor control;
- Training in laryngeal and vocal cord adduction exercises;
- Compensatory swallowing techniques; and
- Oral sensitivity training.

As with all rehabilitation services, there must be a reasonable expectation that the patient will make material improvement within a reasonable period of time.

F. Professional Services

Services are sometimes performed by speech-language pathologists, occupational therapists and physical therapists in concert with other health professionals. Services are often performed as a

team with each member performing unique roles which do not duplicate services of others. Services may include, but are not limited to, the following example.

Example: One professional assisting with positioning, adaptive self-help devices, inhibiting abnormal oromotor and/or postural reflexes while another professional is addressing specific exercises to improve oromotor control, determining appropriate food consistency form, assisting the patient in difficulty with muscular movements necessary to close the buccal cavity or shape food in the mouth in preparation for swallowing. Another professional might be addressing a different role, such as increasing muscle strength, sitting balance and head control.

Intermediaries medically review in accordance with general principles for coverage in MIM §§3101ff. and documentation in PIM Chapter 6 §§5ff., §§6ff., and 7ff.

G. Chronic Progressive Diseases

Patients with progressive disorders, such as Parkinson's disease, Huntington's disease, Wilson's disease, multiple sclerosis, or Alzheimer's disease and related dementias, do not typically show improvement in swallowing function, but will often be helped through short-term assistance/instruction in positioning, diet, feeding modifications, and in the use of self help devices. Intermediaries medically review documentation in support of short-term assistance/teaching and establishment of a safe and effective maintenance dysphagia program.

Chronic diseases such as cerebral palsy, status post-head trauma or stroke (old) may require monitoring of swallowing function with short-term intervention for safety and/or swallowing effectiveness. Documentation should relate to either loss of function, or potential for change. As with other conditions/disorders, the reasonableness and necessity of services must be documented.

Documentation should include:

- Changes in condition or functional status;
- History and outcome of previous treatment for the same condition; and
- Other information which justifies the start of care.

H. Nasogastric Tube or Gastrostomy Tube

The presence of a nasogastric or gastrostomy tube does not preclude need for treatment. Removal of a nasogastric or gastrostomy tube may be an appropriate treatment goal.

I. Safety

Although the documentation must indicate appropriate treatment goals to improve a patient's swallowing function, it must also indicate that the treatment is designed to ensure that it is safe for the patient to swallow during oral feedings. Improving the patient's safety and quality of life by reduction or elimination of alternative nutritional support systems and advancement of dietary level, with improved nutritional intake should be the primary emphasis and goal of treatment. The documentation must be consistent with these goals and indicate the reasonableness and need for skilled intervention.

J. Skilled Level of Care

Documentation of ongoing dysphagia treatment should support the need for skilled services such as observation, treatment, and diet modification. Documentation which is reflective of routine, repetitive observation or cuing may not qualify as skilled rehabilitation.
For example, repeated visits in which the care-giver appears only to be observing the patient eating a meal, reporting on the amount of food consumed, providing verbal reminders (e.g., slow down or cough) in the absence of other skilled assistance or observation suggests a non-skilled or maintenance level of care. Maintenance programs are covered for a brief period and are usually included during the final visits of the professional.

K. Professional Qualifications

Swallowing rehabilitation is a highly specialized service. Intermediaries should assume that the professionals rendering care have the necessary specialized training and experience. They refer any suspected patterns of poor quality to the RO.

L. Consultation

Intermediaries are encouraged to seek consultation/advice from the American Speech-Language-Hearing Association, American Occupational Therapy Association, and American Physical Therapy Association as these claims often require MR by therapy or speech-language pathology consultants.

Appendix

Abbreviations

Explanation of Abbreviations commonly used in Rehabilitation Charting:

A	Assisted
AAROM	Active Assistive Range of Motion
Abd	Abduction
Add	Adduction
ADL	Activities Daily Living
AFO	Ankle Foot Orthosis
AKA	Above Knee Amputation
ALD	Assistive Listening Device
ALS	Anterior Lateral Sclerosis
Amb	Ambulation
AP	Active and Passive
AROM	Active Range of Motion
(B)	Both/Bilateral
BID	Two Time a Day
BKA	Below Knee Amputation
BUE	Bilateral Upper Extremity
C	Cane
c	With
COTA	Certified Occupational Therapy Assistant
CP	Cerebral Palsy
Cr Tr	Crutch Training
CVA	Cerebral Vascular Accident
SWD	Short Wave Diathermy
Dx	Diagnosis
ES	Electrical Stimulation

Appendix

Eval	Evaluation
EXT	Extension
Ext Rot	External Rotation
FLEX	Flexion
Funct Act	Functional Activities
FWB	Full Weight Bearing
Fx	Fracture
HP	Hot Packs
Hx	History
I	Independent
Int Rot	Internal Rotation
IR	Infra Red
KAFO	Knee Ankle Foot Orthosis
L	Left
LB	Low Back
LBQC	Large Based Quad Cane
LE	Lower Extremity
LLC	Long Leg Cast
LLE	Left Lower Extremity
LS	Lumbosacral
LTG	Long Term Goals
LUE	Left Upper Extremity
MD	Muscular Dystrophy
MG	Myasthenia Gravis
MS	Multiple Sclerosis
Max	Maximal
Min	Minimal

Appendix

Mod	Moderate
MW	Microwave
NA	Not Applicable
NBQC	Narrow Based Quad Cane
NPO	Nothing Orally
NS	No Show
NT	Not Tested
ORIF	Open Reduction Internal Fixation
OTR	Occupational Therapist Registered
OT	Occupational Therapy
PRE	Progressive Resistive Exercise
p	Post/After
PROM	Passive Range of Motion
PT	Physical Therapy/Therapist
PTA	Physical Therapy Assistant
Pt	Patient
PU Walker	Pick Up Walker
PWB	Partial Weight Bearing
QD	Daily
R	Right
Rehab	Rehabilitation
RLE	Right Lower Extremity
RNA	Restorative Nursing Aide
ROM	Range of Motion
RUE	Right Upper Extremity
Rx	Treatment
S	Supervised

Appendix

s	Without
SBA	Stand By Assist
SBQC	Small Based Quad Cane
Sdly	Side Living
Sev	Severe
Sh	Shoulder
SLC	Short Leg Cast
SLP	Speech Language Pathologist
SOB	Short of Breath
SSW	Social Service Worker
ST	Speech Therapy
STG	Short-Term Goals
TENS	Transcutaneous Electrical Neural Stimulation
THA	Total Hip Arthroplasty
THR	Total Hip Replacement
TIA	Transient Ischemic Attach
TIW	3 Times a Week
TKR	Total Knee Replacement
TTWB	Toe Touch Weight Bearing
Tx	Traction
tx	Treatment
UE	Upper Extremity
US	Ultra Sound
UV	Ultra Violet
W	Walker
WBAT	Weight Bearing As Tolerated
WC	Wheelchair

Appendix

WFL	Within Functional Limits
WNF	Within Normal Limits
WP	Whirlpool
Up arrow	Increase
Down arrow	Decrease

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-3738
www.harmony-healthcare.com