

Billing and Coding Guidelines

Article Title

Outpatient Rehabilitation Therapy Services billed to Medicare Part B

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Sources

CMS Pub.100-01 Ch.5 §70.6;

CMS Pub.100-02 Ch.15 §60-60.3, 220-230.6, Rev.60.1, 63; *Transmittal 88, Rev 5921

CMS Pub.100-03 Ch.1§§150.1, 150.2, 150.4, 150.8, 160.2, 160.3, 160.12, 160.13, 160.15, 230.8, 240.3, 240.7, 270.6

CMS Pub.100-04 Ch.5 § 10.2, 20.4, Rev.1183

Coverage Topic

Physical and Occupational Therapy

Coding Information

Modifiers

GO - Service Delivered Under An Outpatient Occupational Therapy Plan of Care

GP - Service Delivered Under An Outpatient Physical Therapy Plan of Care

KX - Specific Required Documentation on File

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

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

1. List the appropriate procedure code for the service performed, include any necessary modifiers.
 - a. PT/OT/SPL services personally performed by a qualified professional in their office location or a beneficiary's home should be reported to Medicare under the physicians/NPPs Medicare NPI, with an appropriate HCPCS/CPT code and the appropriate therapy modifier (GN, GO, GP).
 - b. PT/OT/SPL services performed, by a qualified clinician employed by a physician/NPP or physician/NPP group **without** a Medicare NPI should be reported to Medicare under the physicians/NPPs Medicare NPI, with an appropriate HCPCS/CPT code and the appropriate therapy modifier (GN, GO, GP). These services must be performed under the physicians/NPP direct supervision in the office.
 - c. PT/OT services, performed by a qualified professional in independent practice employed by a physician/NPP or physician/NPP group **with** a Medicare NPI, should be reported to Medicare, with an appropriate HCPCS/CPT code and the appropriate therapy modifier (GN, GO, GP).

- d. A KX modifier should be reported on a claim identified as therapy services with a GN, GO, GP modifier when the therapy cap exception has been approved or the guidelines for an automatic exception is met and the therapy cap is exceeded. **Do not apply the KX modifier to therapy service claims unless the therapy cap is exceeded and the therapy cap exceptions are met.**
2. Physicians/NPPs, independent physical therapists, and independent occupational therapists may bill for physical therapy services using the CPT physical medicine and rehabilitation codes. For evaluations/re-evaluations, physical therapists should use CPT code 97001 and CPT code 97002, and occupational therapists should use CPT code 97003 and CPT code 97004. For evaluation/re-evaluations physician/NPP should report the appropriate E&M code.
 3. When both PM&R services and evaluation service are reported on the same date of service, the evaluation may be reimbursed if the evaluation is clearly and separately documented. Re-evaluation services reported on a routine basis with each PM&R treatment session may be subject to review.
 4. List the appropriate ICD-9 code that best supports the medical necessity for the service. ICD-9 codes must be present on all claims and must be coded to the highest degree of accuracy and digit level completeness. Claims lacking ICD-9 codes, coded to the highest degree of accuracy and digit level completeness will be denied as unprocessable.
 - a. Report the patient's specific condition for which the current therapy episode of care services is being performed in the first position in Item 21 of the CMS1500 claim form or electronic format equivalent field.
 - b. Report existing conditions, complexities, or circumstances influencing the length or intensity of the current therapy episode of care in the remaining positions.
 - c. When physical medicine and rehabilitation services are performed for beneficiaries who have suffered musculoskeletal or neurological complications secondary to some other disease, use the ICD-9-CM code for the sign/symptom/complication diagnosis. The underlying condition may also be coded, but is not required. However, the underlying, causal pathological condition alone will not be sufficient for coverage.

For example, when a patient suffers a Colles' fracture (813.41), the appropriate diagnosis code for physical medicine and rehabilitation services is stiffness of joint-forearm (ICD-9 code 719.53). Submitting ICD-9 code 813.41 alone without submitting ICD-9 code 719.53 will result in claim denial.
 5. When physical medicine and rehabilitation services are performed for beneficiaries who have suffered musculoskeletal or neurological complications secondary to other disease, report the complication diagnosis as the primary diagnosis, not the underlying condition. For example,
 - a. When patients have become disabled due to prolonged inactivity resulting from a cardiac condition, report ICD-9 codes 728.2, 799.3, 799.4, not the ICD-9 code(s) for the cardiac condition.
 - b. For therapy after corrective surgery for deformities, report the appropriate ICD-9 codes for therapy condition being treated, not the codes for the congenital or acquired deformity.
 6. For Correct Coding (CCI) combinations refer to the separately available manual or the CMS web site. <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>
 7. When reporting time units for treatments, report each 15 minutes as one (1) unit. Do not report the actual time of the treatment in the quantity/units field. The PM&R codes should **not** be reported multiple times per day when the same codes are used for treatment of multiple body areas, the time units should be combined for same treatment to multiple body areas.

8. When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. screening), report a screening ICD-9 code and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit)
9. When billing for services, that would be expected to be denied as **not** reasonable and necessary (See Denial Summary – Medical Necessity 1-14), report an **ICD-9 code V57.9-unspecified rehabilitation procedure** and the GA modifier (waiver of liability on file) if an ABN signed by the beneficiary is on file or the GZ modifier (items or services expected to be denied as not reasonable) when a signed ABN for the service is not on file.
11. When both a modality/procedure and an evaluation service are billed on the same day, the evaluation may be reimbursed only if the medical necessity for the evaluation is clearly documented.
12. CPT code 97140 (Manual therapy techniques) excludes manipulation performed in the home setting.
13. CPT code 90911 is not covered unless EMG and/or manometry are included. Biofeedback therapy differs from electromyography, which is a diagnostic procedure used to record and study the electrical properties of skeletal muscle. An electromyography device may be used to provide feedback with certain types of biofeedback.

Definitions

A. Definitions *The following defines terms used in this section and §230:*

ACTIVE PARTICIPATION *of the clinician in treatment means that the clinician personally furnishes in its entirety at least 1 billable service on at least 1 day of treatment.*

ASSESSMENT *is separate from evaluation, and is included in services or procedures, (it is not separately payable). The term assessment as used in Medicare manuals related to therapy services is distinguished from language in Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment, which may be payable). Assessments shall be provided only by clinicians, because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation (see definitions below) is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.*

CERTIFICATION *is the physician's/nonphysician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.*

The CLINICIAN *is a term used in this manual and in Pub 100-04, chapter 5, section 10 or section 20, to refer to only a physician, nonphysician practitioner or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law. Clinicians make clinical judgments and are responsible for all services they are permitted to supervise. Services that require the skills of a therapist, may be appropriately furnished by clinicians, that is, by or under the supervision of qualified physicians/NPPs when their scope of practice, state and local laws allow it and their personal professional training is judged by Medicare contractors as sufficient to provide to the beneficiary skills equivalent to a therapist for that service.*

COMPLEXITIES *are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses*

(ICD-9 codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

A DATE may be in any form (written, stamped or electronic). The date may be added to the record in any manner and at any time, as long as the dates are accurate. If they are different, refer to both the date a service was performed and the date the entry to the record was made. For example, if a physician certifies a plan and fails to date it, staff may add "Received Date" in writing or with a stamp. The received date is valid for certification/re-certification purposes. Also, if the physician faxes the referral, certification, or re-certification and forgets to date it, the date that prints out on the fax is valid. If services provided on one date are documented on another date, both dates should be documented.

The EPISODE of Outpatient Therapy – For the purposes of therapy policy, an outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under the care of the clinician (e.g., for evaluation or treatment) for the current condition(s) being treated by one therapy discipline (PT, or OT, or SLP) until the last date of service for that discipline in that setting. During the episode, the beneficiary may be treated for more than one condition; including conditions with an onset after the episode has begun. For example, a beneficiary receiving PT for a hip fracture who, after the initial treatment session, develops low back pain would also be treated under a PT plan of care for rehabilitation of low back pain. That plan may be modified from the initial plan, or it may be a separate plan specific to the low back pain, but treatment for both conditions concurrently would be considered the same episode of PT treatment. If that same patient developed a swallowing problem during intubation for the hip surgery, the first day of treatment by the SLP would be a new episode of SLP care.

EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, reevaluations must also meet Medicare coverage guidelines. The decision to provide a reevaluation shall be made by a clinician.

INTERVAL of certified treatment (certification interval) consists of 90 calendar days or less, based on an individual's needs. A physician/NPP may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report period. **NONPHYSICIAN PRACTITIONERS (NPP)** means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services.

PHYSICIAN with respect to outpatient rehabilitation therapy services means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine, or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered

physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

PATIENT, *client, resident, and beneficiary are terms used interchangeably to indicate enrolled recipients of Medicare covered services.*

PROVIDERS *of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services. To qualify as providers of services, these providers must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made. Note that the word PROVIDER in sections 220 and 230 is not used to mean a person who provides a service, but is used as in the statute to mean a facility or agency such as rehabilitation agency or home health agency.*

QUALIFIED PROFESSIONAL *means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies. Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law. Assistants are limited in the services they may provide (see section 230.1 and 230.2) and may not supervise others.*

QUALIFIED PERSONNEL *means staff (auxiliary personnel) who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP. See §230.5 of this manual. Qualified personnel may or may not be licensed as therapists but meet all of the requirements for therapists with the exception of licensure. SIGNATURE means a legible identifier of any type acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.4.1.1 (B) concerning signatures.*

SUPERVISION LEVELS *for outpatient rehabilitation therapy services are the same as those for diagnostic tests defined in 42CFR410.32. Depending on the setting, the levels include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).*

SUPPLIERS *of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701-729, and 486.150-163. Speech-language pathologists are not suppliers because the Act does not provide coverage of any speech-language pathology services furnished by a speech-language pathologist as an independent practitioner. (See §230.3.)*

THERAPIST *refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, 230.2, and 230.3. Skills of a therapist are defined by the scope of practice for therapists in the state). THERAPY (or outpatient rehabilitation services) includes only outpatient physical therapy, occupational therapy and speech-language pathology services paid using the Medicare Physician Fee Schedule or the same services when provided in hospitals that are exempt from the hospital Outpatient Prospective Payment*

System and paid on a reasonable cost basis, including critical access hospitals. Therapy services referred to in this manual are those skilled rehabilitative services provided according to the standards and conditions in CMS manuals, (e.g., in this chapter and in Pub. 100-04, Medicare Claims Processing Manual, chapter 5), within their scope of practice by qualified professionals or qualified personnel, as defined in this section, represented by procedures found in the American Medical Association's "Current Procedural Terminology (CPT)." A list of CPT (HCPCS) codes is provided in Pub. 100-04, chapter 5, §20, and in Local Coverage Determinations developed by contractors. Unless modified by the words "maintenance" or "not", the term therapy refers to rehabilitative therapy services as described in §220.2(C).

TREATMENT DAY means a single calendar day on which treatment, evaluation and/or reevaluation is provided. There could be multiple visits, treatment sessions/encounters on a treatment day.

VISITS OR TREATMENT SESSIONS begin at the time the patient enters the treatment area (of a building, office, or clinic) and continue until all services (e.g., activities, procedures, services) have been completed for that session and the patient leaves that area to participate in a non-therapy activity. It is likely that not all minutes in the visits/treatment sessions are billable (e.g., rest periods). There may be two treatment sessions in a day, for example, in the morning and afternoon. When there are two visits/treatment sessions in a day, plans of care indicate treatment amount of twice a day.

Treatment Time

Documentation of services is part of the coverage of the respective CPT code; therefore there is no separate coverage for time spent on documentation.

Counting Minutes for Timed Codes in 15 Minute units

(a.) *When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.*

(Pub. 100-4, Chap. 5, § 20.2)

(b.) *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.*

(Pub. 100-4, Chap. 5, § 20.2)

(c.) *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.* (Pub. 100-4, Chap. 5, § 20.2)

2. Time intervals for 1 through 8 units are as follows:

Units Number of Minutes

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 112 minutes CPT code

8 units: ≥ 113 minutes through 127 minutes

(Pub. 100-4, Chap. 5, § 20.2)

The time spent delivering each service, described by a timed code, should be recorded. (The length of the treatment to the minute could be recorded instead.) If more than one 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. For example, if 24 minutes of CPT code 97112 and 23 minutes of CPT code 97110 were furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is

2 units of CPT code 97112 and one unit of CPT code 97110, assigning more units to the service that took the most time.

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 timing of active treatment counted includes all direct treatment time.

Determining What Time Counts Towards 15 Minute Timed Codes. Qualified practitioners 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 "intraservice care" begins when the clinician or physician/NPP (or an assistant under the supervision of a physician/NPP or clinician) 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 clinician and an assistant, or even two clinicians, to manage in the parallel bars, each 15 minutes the patient is being treated can only count as one unit of CPT 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.

Denial Summary

The following situations will result in the denial of the initially billed PM&R services or in some cases as result of a post-payment review.

Chiropractors and doctors of dental medicine/surgery are not considered physicians for PM&R services; they may not refer patients for treatment or establish/certify therapy care plans.

Physical therapists may not perform chiropractic manipulations, but they may perform osteopathic manipulation, provided the performance fall within their scope of practice defined by their state law. The services of an athletic trainer, massage therapist, recreation therapist, kinesiotherapist, low vision specialist or other like profession may not be billed to Medicare as therapy services incident to physicians services.

Medical Necessity:

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section excludes coverage and payment for items and services that are not considered reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member.

1. Heat Treatment, Including the Use of Diathermy (CPT code 97024) and Ultra-Sound (CPT code 97035) for Pulmonary Conditions
2. There is no physiological rationale or valid scientific documentation of effectiveness of diathermy or ultrasound heat treatments for asthma, bronchitis, or any other pulmonary condition and for such purpose this treatment cannot be considered reasonable and necessary within the meaning of §1862(a)(1) of the Act.
3. Electrical stimulation (HCPCS code G0283; CPT code 97032) is considered not reasonable and necessary and is excluded from Medicare coverage for the following:
 - a. motor nerve disorders such as Bell's Palsy. (ICD-9 code 351.0)
 - b. TENS treatments and related services (i.e. CPT code 64550), furnished in physicians/NPP or therapist's office. (See CMS Pub.100-2 Ch.16 §180, CMS Pub.100-3 §160.3)
 - c. Electrical Stimulation is not medically necessary for the treatment of strokes when there is no potential for restoration of function.

4. Services determined to be performed solely for maintenance purposes.
5. Services performed with excessive frequency, duration will be denied as not reasonable or necessary.
6. Hippotherapy is the use of the movement of a horse as a tool to address impairment, functional limitations and disabilities in patients with neuromuscular dysfunction. In reviewing the available literature regarding the use of Hippotherapy for this population of patients it does not show sufficient randomized and controlled studies published in peer-review journals demonstrating the evidence of this therapeutic intervention to be safe and effective. Services using hippotherapy as a treatment tool is not standard in therapeutic programs for these populations and will be denied as not medically necessary at this time.
7. Re-evaluation reported on a routine basis with each PM&R treatment session will be denied as not medically necessary.
8. Microwave Therapy:
Because there is no evidence from published, controlled clinical studies demonstrating the efficacy of this modality, this service will be denied as not reasonable and necessary.
9. "Balneo Phototherapy" (CPT code 96999). This is not standard medical treatment for psoriasis and is not medically necessary or covered.
10. It is not medically necessary for a supplier to perform or supervise maintenance programs that do not require the professional skills of a supplier. These situations include:
 - a. Services related to activities for the general good and welfare of patients (i.e., general exercise to promote overall fitness and flexibility);
 - b. Repetitive exercises to maintain gait or maintain strength and endurance, and assisted walking such as that provided in support for feeble or unstable patients; and
 - c. Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities.
 - d. Continued billing of PM&R CPT codes (CPT code 97012-97546) after the patient has achieved therapeutic goals or for patients who show no further meaningful progress.
11. Services provided by therapy aides under the supervision of clinicians in independent practice are considered non-skilled services and will be denied as not medically necessary.
12. PM&R services performed by athletic trainer, massage therapist, recreation therapist, kinesiologist, low vision specialist or other like profession "incident to" physician's/NPP's service are considered non-skilled services and will be denied as not medically necessary.
13. OT/PT evaluations/re-evaluation will be denied as not medically necessary when performed by OP/PT assistants.
14. VAX-D: This non-invasive spinal decompression service, despite FDA approval of the relevant devices, is not considered medically reasonable and necessary under Medicare. See CMS Pub.100-3 §160.16
15. *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, 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. Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) if the claim contains any of the following ICD-9 codes:
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.*
16. Lack of documentation for the trial pelvic muscle training (*Non-Implantable Pelvic Floor Electrical Stimulators*) will result in the ES services being denied as not medically necessary.

Non-Covered:

Title XVIII of the Social Security Act section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

1. Physician/NPP's Services submitted without an ICD-9 code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.
2. PM&R services subject to ANY annual financial limitation, or claims not reported with modifiers GN, GO, or GP will be denied as unprocessable.
3. Services exceeding the OT/PT Rehab. Financial Limit will be denied as non-covered.
4. PM&R services are not covered when the certification/recertification is not performed by the attending physician/NPP every 90 days.
5. Topical medication used with Iontophoresis is a Medicare excluded service and will be denied as non-covered
6. Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services.
7. PM&R services performed or ordered/referred by chiropractors and doctors of dental medicine/surgery will be denied as not-covered.
8. Chiropractic manipulations performed by physical therapists will be denied as non-covered.
9. PM&R services performed on a random basis, for the good and welfare of the patient do not meet the conditions for payment in 42CFR424.24c and SSA§1835(a)(2)(D) and will be denied as not covered.
10. PM&R services performed without the establishment of a plan of care do not meet the conditions for payment in 42CFR424.24c and SSA§1835(a)(2)(D) and will be denied as not covered.

Notes

Italicized font – represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Qualified practitioners, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at [*\(www.cms.hhs.gov/DeterminationProcess/\)](http://www.cms.hhs.gov/DeterminationProcess/). An asterisk (*) indicates a revision to that section of the policy.

Other Versions

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Revision Date/Number/Explanation

12/01/2009, This replaces the billing and coding from Legacy B: L28531 PHYSMED-009 Physical Medicine and Rehabilitation; NCP PHYS-001 Outpatient Physical Therapy, **MAC B: L26688** PHYSMED-509 Physical Medicine and Rehabilitation;