I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Facility”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to ensure that Outpatient Therapy services in the hospital provider based setting are appropriately provided and billed.

III. DEFINITIONS:

A. “Therapy” or “Therapies” means Outpatient Physical Therapy, Occupational Therapy and/or Speech Language Pathology services.

B. “Physician” means, in the context of this policy, a medical doctor or any licensed independent practitioner, such as a nurse practitioner, clinical nurse specialist or physician’s assistant, who is authorized by state law to order tests or services and/or is legally accountable for establishing the patient’s diagnosis.

IV. POLICY:

All Therapy services provided in the hospital provider based setting must meet the appropriate medical necessity criteria and all Therapy services must be reasonable and necessary as they apply to decisions for Plans of Care, continuing treatment and discharge. Therapies provided by Tenet Facilities must meet the provision of service, medical necessity, and documentation requirements stated in this policy. This policy applies to all payers unless otherwise specified within.

V. PROCEDURE:

A. Facility Implementation

1. Criteria for the Provision of Therapy Services

   a. All documented and billed Therapy services must be provided by a “Qualified Professional,” defined as a physical therapist, occupational therapist, or speech-language pathologist. Physical therapist assistants and occupational therapist assistants, when working under the supervision of a qualified therapist, within the scope of practice allowed by state law, are also considered Qualified Professionals. Assistants are limited in the services they may provide
b. Services provided by aides/techs, athletic trainers and massage therapists, even if under the supervision of a therapist, are not skilled Therapy services and therefore cannot be billed to Federal health care programs. In cases where the managed care company or worker’s compensation has preauthorized the use of non-Therapy personnel they may provide services under the direction of the clinician. (Medicare Benefit Policy Manual Chapter 15, Section 220.2A)

c. Students may participate in and observe the provision of Therapy by a licensed therapist, and the Therapy provided by the licensed therapist must be billed in accordance with this policy, when the licensed therapist is directing the service, making the skilled judgment and is responsible for the assessment and treatment of the patient. The therapist must be present and in the room for the entire session, guiding the student in service delivery, when the student is participating in the provision of services and not be engaged in treating another patient or completing other tasks at the same time. The licensed therapist is responsible for the services and as such, signs all documentation. This requirement applies to all payers. (Medicare Benefit Policy Manual Chapter 15, Section 230B)

d. The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition. (Medicare Benefit Policy Manual Chapter 15, Section 220.2B)

e. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a therapist. In the case of a physical therapist assistant or occupational therapist assistant services must be performed under the supervision of a therapist. (Medicare Benefit Policy Manual Chapter 15, Section 220.2B)

f. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary Therapy services, even if they are performed or supervised by a Qualified Professional. (Medicare Benefit Policy Manual Chapter 15, Section 220.2B)
g. There must be the expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. (Medicare Benefit Policy Manual Chapter 15, Section 220.2B)

h. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. (Medicare Benefit Policy Manual Chapter 15, Section 220.2B)

i. Therapy is not required to affect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual’s illness or injury. (Medicare Benefit Policy Manual Chapter 15, Section 220.2B)

2. **Physician Referral** (Medicare Benefit Policy Manual Chapter 15, Section 220.1.1)

a. There must be a referral from a Physician for the Therapy evaluation and associated treatment. The referral must include:

   (1) Patient name
   
   (2) Diagnosis
   
   (3) Treatment referral, described through a narrative and/or CPT code and requested through:

   (a) written Physician referral; or
   
   (b) verbal referral, received only by Qualified Individuals, reduced to writing, and authenticated by the Physician as specified in the Tenet Facility’s Medical Staff bylaws and Regulatory Compliance Policy COMP-RCC 4.03 Hospital Chart Completion, Documentation and Security;

   Receiving both a narrative description and a CPT code is strongly preferred.
3. Evaluations

a. Evaluations are required prior to beginning therapy for determining the medical necessity of initiating rehabilitative or maintenance services. Patients must exhibit a significant change from normal functional ability to warrant an evaluation.

b. Following the evaluation, a Plan of Care must be established. A referral from the Physician stating that the therapist should “Evaluate and Treat” the patient is not sufficient to support Therapy provided after the evaluation. After performing the evaluation, the therapist or Physician must establish a Plan of Care for the Therapies recommended by the therapist.
c. When an evaluation is the only service provided by a provider in an episode of treatment, the evaluation serves as the Plan of Care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring Physician. The goal, frequency, intensity and duration of treatment are implied in the diagnosis and one-time service. The referral of a Physician is the certification that the evaluation is needed and the patient is under the care of a Physician. Therefore, when evaluation is the only service, a referral and evaluation are the only required documentation.

4. Plan of Care (Medicare Benefit Policy Manual Chapter 15, Section 220.1 – 220.1.3)
   a. Therapies must be furnished under a written Plan of Care established by:
      (1) A Physician (consultation with the treating therapist is recommended)
      (2) The therapist who will provide the Therapy services
   b. Therapy may begin before the Plan of Care is committed to writing only if the Therapy is performed or supervised by the same qualified professional who establishes the Plan of Care and that Plan of Care is reduced to writing and signed by the close of business on the next day by the same qualified professional.
   c. The following information must be included in the Plan of Care:
      (1) Diagnosis
      (2) Long-term treatment goals with target dates to address functional limitations in terms that are objective and measurable
      (3) Treatment plan including specific therapeutic modalities and procedures
      (4) Frequency and duration of treatment
      (5) Signature and professional identity of the person who established the plan
      (6) The date the plan was established
d. Plan of Care for Medicare Patients

(1) Certification is the Physician’s approval of the Plan of Care. The Tenet Facility must not bill for the Therapy until the Physician has signed the Plan of Care. Certification requires the Physician’s dated signature on the Plan of Care (or some other document that indicates specific approval of the Plan of Care). Acceptable documentation of certification is:

- A Plan of Care that is signed and dated during the interval of treatment by the Physician. This can be the Therapy evaluation or a separate Plan of Care document

- A Physician progress note signed and dated during the interval of treatment that specifically acknowledges the Plan of Care

(2) The signed certification indicates that the Physician is aware that Therapy service is or was in progress and the Physician makes no record of disagreement with the Plan when there is evidence that the Plan was sent or is available in the record for the Physician to review. It is not appropriate for a Physician to certify a Plan of Care if the patient was not under the care of the Physician at the time of the treatment or if the patient did not need the treatment. The certification should be retained in the clinical record.

(a) Initial Certification of the Plan – the Physician must certify the Plan as soon as it is obtained. The initial Plan of Care should be developed based on the outcome of the initial evaluation, the patient’s needs, and the professional judgment of the therapist. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

(b) Plan Recertification – payment and coverage conditions require that the Plan must be reviewed, signed and dated by a Physician at least every 90 days unless the Physician specifies a shorter time frame. If Therapy beyond the first treatment interval is deemed necessary, the Physician
responsible for the patient’s care at the time must review and recertify the Plan before or during the subsequent interval of treatment. The Physician must review the Plan as often as the individual’s condition warrants.

(c) While the Physician may change a Plan of treatment established by the therapist providing such services, the therapist may not significantly alter a treatment plan established or certified by a Physician without his/her documented written or verbal approval.

(i) A change in long term goals (or if a new condition was to be treated) would be a significant change. This will require that the revised Plan of Care be recertified within 30 calendar days after the initial therapy treatment under that Plan.

(ii) An insignificant alteration would be a decrease in the frequency or duration due to the patient’s illness, or modification of short term goals to adjust for improvements made toward the same long term goals. If a patient has achieved a goal and/or has had no response to a treatment that is part of the Plan, the therapist may delete a specific intervention from the Plan of Care prior to Physician approval.

(iii) Changes to procedures and modalities do not require Physician signature when they represent adjustments to the Plan that result from a normal progression in the patient’s disease or condition. Only when the patient’s condition changes significantly, making revision of long term goals necessary, is a Physician signature required on the change.

(d) Delayed Certification – certification is timely when the certification occurs before or during the treatment interval. Certification and recertification requirements are deemed satisfied where, at any later date, a Physician makes certification accompanied by a
reason for the delay. Certifications are acceptable without justification for 30 days after they are due. Delayed certification should include any evidence the Tenet Facility considers necessary to justify the delay. In the case of a long delayed certification (over 6 months), the Tenet Facility may choose to submit with the delayed certification some other documentation indicating need for care and that the patient was under the care of a Physician at the time of the treatment. *It is not intended that needed Therapy be stopped or denied when certification is delayed.*

e. Plan of Care for Managed Care Patients

The Plan of Care is a component of the evaluation and must be completed and filed in the medical record as such. The Physician *does not* need to certify/recertify the Plan of Care as preauthorization/authorization from the managed care companies acts as such.

B. Delivery of Care - Requirements Applicable to all Payers

1. Individual Therapy: To perform individual Therapy, the therapist, therapist assistant, or speech language pathologist must be in constant attendance with one patient and must provide direct, one-on-one attention to that patient. There may be other patients in the room or gym but the therapist, therapist assistant, or speech language pathologist cannot be providing any services to other patients including supervision or verbal cueing. 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 sufficient length of time to provide the appropriate skilled treatment in accordance with each patient’s Plan of Care. The manner of practice should clearly distinguish it from care provided simultaneously to two or more patients. (Medicare Claims Processing Manual Chapter 5, Section 20)

2. Non-Skilled Services: Tenet Facilities may provide non-skilled services to a managed care or workers’ compensation patient if the provision of such service is precertified by the payer.

3. Group Therapy: consists of simultaneous treatment to two or more patients who may or may not be doing the same activities. Group therapeutic procedures require the constant attendance of the Physician or
therapist but by definition do not require one-on-one contact by the Physician or therapist. Since most group procedures do not require the professional skills of a therapist, coverage of these procedures for Federal health care program beneficiaries will be determined by the Medicare Administrative Contractor on an individual case basis. Case management techniques such as “dove tailing” could constitute group therapy. The length of group therapy sessions must be of sufficient length to address the needs of each patient in the group. (Medicare Claims Processing Manual Chapter 5, Section 20)

a. 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, the therapist must bill each patient one unit of group therapy.

b. Generally a group therapy session will be provided to the same patient only once each day. In the occasional situation where more than one group therapy session is provided to one patient in one day, the therapist must provide sufficient documentation to support its medical necessity and clinical appropriateness.

c. Documentation must identify specific treatment techniques, how the technique will restore function, the frequency and duration of the group and the treatment goal in the plan.

4. Maintenance Program: The services of a Qualified Professional are not necessary to carry out a maintenance program. The specialized skill, knowledge and judgment of a therapist would be required to design or establish the plan, ensure patient safety, train the patient, family members and make infrequent but periodic reevaluations of the plan. (Medicare Claims Processing Manual Chapter 15, Section 220.2)

C. Documentation Requirements Applicable to all Payers

See Job Aid titled Documentation and Billing: Outpatient Therapy in the Hospital Provider Based Setting.

D. Therapy Caps Exception Process (Medicare Claims Processing Manual Chapter 5, Section 20)

Medicare Part B Therapy cap limits are set annually for Physical Therapy and Speech Language Pathology as a combined dollar amount. There is a single amount established for Occupational Therapy that equals the combined amount.
1. A patient may qualify for an exception beyond the Therapy cap when the patient’s condition is justified by documentation indicating the patient requires continued skilled Therapy to achieve prior functional status or maximum expected functional status within a reasonable period of time. Documentation must support that the services were medically necessary. Clinicians should consider whether:
   a. Services are appropriate to the patient’s condition (diagnosis, complexities and severity);
   b. The services provided (type, frequency and intensity); and
   c. The interaction of the current active conditions and complexities that influence treatment, causing it to exceed the Therapy caps.

2. Billing Guidelines: The KX modifier is used when the beneficiary qualifies for the Therapy cap exception. By adding this modifier, the provider is attesting that the services billed qualified for the Therapy cap exception, are reasonable and necessary and are justified by appropriate documentation. If this attestation is inaccurate, the provider will be subject to sanctions for putting inaccurate information on the claim.

E. Functional Reporting (Medicare Claims Processing Manual Chapter 5, Section 20)

Medicare’s claims based data reporting requires selected claims for Therapy services to include non-payable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary’s functional status at the onset of the therapy episode of care, at specified points during treatment and at the time of discharge. These G-codes and modifiers are required on all Medicare primary and secondary claims. See Job Aid titled Functional Reporting: Outpatient Therapy in the Hospital Provider Based Setting for specifics.

F. Responsible Person

The Director of Rehabilitation Services or designee is responsible for assuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Facility, and that instances of noncompliance with this policy are reported to the Compliance Officer.

G. Auditing and Monitoring

The Quality Management Department will audit compliance with this policy as part of its Comprehensive Clinical Audits. Audit Services will audit compliance with this policy as part of its routine audits.
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H. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, “Covered Medical and Other Health Services,” sections 220 and 230
- Medicare Claims Processing Manual, Chapter 5
- Medicare Learning Network “Outpatient Therapy Functional Reporting Requirements.” July 1, 2013
- CMS Transmittal 2622, December 21, 2012
- CMS Transmittal 2121, December 17, 2010
- Medicare Learning Network “Medicare Outpatient Therapy Billing”, August 2010
- CMS Transmittal 1851, November 13, 2009
- CMS Transmittal 88, May 7, 2008
- CMS Transmittal 63, December 29, 2006
- CMS Transmittal 1145, December 29, 2006
- CMS Transmittal 60, November 9, 2006
- CMS Transmittal 140, February 15, 2006
- CMS Transmittal 855, February 15, 2006
- CMS Transmittal 36, June 24, 2005
- CMS Transmittal 5, January 9, 2004
- Frequently Asked Questions Post CMS Open Door Forum on 9/13/02 on Group Therapy and references cited therein
- Regulatory Compliance Policy COMP-RCC 4.03 Health Information Management Operations, Hospital Chart Completion, Documentation and Security
- Regulatory Compliance Policy COMP-RCC 5.01 Orders for Outpatient Tests and Services