CMS Manual System

Pub. 100-02 Medicare Benefit Policy

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 9 **Date: APRIL 23, 2004**

CHANGE REQUEST 3134

I. SUMMARY OF CHANGES: This manual is updated to clarify information regarding arrangements for physical, occupational, and speech-language pathology services.

NEW/REVISED MATERIAL—EFFECTIVE DATE: May 24, 2004
***IMPLEMENTATION DATE: May 24, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	15/220.1/Therapy Services Furnished Under Arrangements with Providers and Clinics

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Arrangements for Physical, Occupational, and Speech Language Pathology Services (PT, OT, SLP)

I. GENERAL INFORMATION

A. Background: This update clarifies information already published in the manual.

B. Policy: The manual update clarifies arrangements for PT/OT/SLP services

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. Contractors will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in their next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS:

Requirement #	Requirements	Responsibility
3134	Contractors shall post the article referred to in I C above, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in their next regularly scheduled bulletin.	Medicare Contractors

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: May 24, 2004 **Implementation Date:** May 24, 2004 **Pre-Implementation Contact(s):** Dorothy Shannon 410-786-3396 or Tamar Spolter 410-786-4709 **Post-Implementation Contact(s)**: Dorothy Shannon 410-786-3396 or Tamar Spolter 410-786-4709	**These instructions shall be implemented within your current operating budget**

220.1 - Therapy Services Furnished Under Arrangements with Providers

(Rev. 9, 04-23-04)

B3-2203; A3-3147.1; HO-241.1; Pub 100-1, Chapter 5, §10.3

A. General

A provider may have others furnish outpatient therapy (physical therapy, occupational therapy, or speech-language pathology) services through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service.

However, it is not intended that the provider merely serve as a billing mechanism for the other party. For such services to be covered the provider must assume professional responsibility for the services.

The provider's professional supervision over the services requires application of many of the same controls as are applied to services furnished by salaried employees. The provider must:

- Accept the patient for treatment in accordance with its admission policies;
- Maintain a complete and timely clinical record on the patient which includes diagnosis, medical history, orders, and progress notes relating to all services received;
- Maintain liaison with the attending physician or non-physician practitioner with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by the physician;
- Secure from the physician or non-physician practitioner the required certifications and recertifications; and
- See to it that the medical necessity of such service is reviewed on a sample basis by the agency's staff or an outside review group.

In addition, when a provider provides outpatient services under an arrangement with others, such services must be furnished in accordance with the terms of a written contract, which provides for retention by the provider of responsibility for and control and supervision of such services. The terms of the contract should include at least the following:

- Provide that the therapy services are to be furnished in accordance with the plan of care established by the physician or non-physician practitioner after any necessary consultation with the physical therapist, occupational therapist, or speech-language pathologist as appropriate, who will provide the therapy services.
- Specify the geographical areas in which the services are to be furnished;

- Provide that personnel and services contracted for meet the same requirements as those which would be applicable if the personnel and services were furnished directly by the provider;
- Provide that the therapist will participate in conferences required to coordinate the care of an individual patient;
- Provide for the preparation of treatment records, with progress notes and observations, and for the prompt incorporation of such into the clinical records of the clinic;
- Specify the financial arrangements. The contracting organization or individual may not bill the patient or the health insurance program; and
- Specify the period of time the contract is to be in effect and the manner of termination or renewal.

B. Hospitals

- *A hospital may bill Medicare for outpatient therapy (physical therapy, occupational therapy, or speech-language pathology) services that it furnishes to its outpatients either directly or under arrangements in the hospital's outpatient department. If a hospital furnishes medically necessary therapy services in its outpatient department to individuals who are registered as its outpatients, those services must be billed directly by the hospital using bill type 13X or 85X for Critical Access Hospitals. Note that services provided to residents of a Medicare-certified SNF may not be billed by the hospital as services to its outpatients.*
- *When a hospital sends its therapists to the home of an individual who is registered as an outpatient of the hospital but who is unable, for medical reasons, to come to the hospital to receive medically necessary therapy services, the services must meet the requirements applicable to outpatient hospital therapy services, as set forth in the regulations and applicable Medicare Manuals. The hospital may bill for those services directly using bill type 13X or 85X for Critical Access Hospitals.*
- *If a hospital sends its therapists to provide therapy services to individuals who are registered as its outpatients and who are residing in the non-certified part of a SNF, or in another residential setting (e.g., a group home, assisted living facility or domiciliary care home), the hospital may bill for the services as hospital outpatient services if the services meet the requirements applicable to outpatient hospital therapy services, as set forth in the regulations and applicable Medicare Manuals.*
- *A hospital may make an arrangement with another entity such as an Outpatient Rehab Facility (Rehabilitation Agency) or a private practice, to provide therapy services to individuals who are registered as outpatients of the hospital. These services must meet the requirements applicable to services furnished under arrangements and the requirements applicable to the outpatient hospital therapy services as set forth in the regulations and*

applicable Medicare Manuals. The hospital uses bill type 13X or 85X for Critical Access Hospitals to bill for the services that another entity furnishes under arrangement to its outpatients.

- *In certain settings and under certain circumstances, hospitals may not bill Medicare for therapy services as services of the hospital:*
  - *If a hospital sends its therapists to provide therapy services to patients of another hospital, including a patient at an inpatient rehabilitation facility (IRF) or a long term care (LTC) facility, the services must be furnished under arrangements made with the hospital sending the therapists by the hospital having the patients and billed as hospital services by the facility whose patients are treated. These services would be subject to existing hospital bundling rules and would be paid for under the payment method applicable to the hospital at which the individuals are patients.*
  - *A hospital may not send its therapists to provide therapy services to individuals who are receiving services from a home health agency (HHA) under a home health plan of care and bill for the therapy services as hospital outpatient services. For patients under a home health plan of care, payment for therapy services (unless provided by physicians) is included or bundled into Medicare's episodic payment to the HHA, and those services must be billed by the HHA under the HHA consolidated billing rules. For patients receiving HHA services under a HHA plan of care, therapy services must be furnished directly or under arrangements made by the HHA, and only the HHA may bill for those services.*
  - *If a hospital sends its therapists to provide services under arrangements made by a SNF to residents of the Medicare-certified part of a SNF, SNF consolidated billing rules apply. This means that therapy services furnished to SNF residents in the Medicare-certified part of a SNF cannot be billed by any entity other than the SNF.*

    Therefore, a hospital may not bill Medicare for PT/OT/SLP services furnished to residents of a Medicare-certified part of a SNF by its therapists as services of the hospital.

    Note: If the SNF resident is in a covered Part A stay, the therapy services would be included in the SNF's global PPS per diem payment for the covered Part A stay itself. If the resident is in a noncovered stay (Part A benefits exhausted, no prior qualifying hospital stay, etc.), but remains in the Medicare-certified part of a SNF, the SNF would submit the Part B therapy bill to its fiscal intermediary.

SNF Setting	***Applicable Rules***

Medicare Part A or B	***Consolidated Billing Rules Apply?***	***Hospital May Bill For Outpatient Services?***
Part A (Medicare Covered / PPS) Resident in Medicare-certified part of a SNF	*Yes*	*No*
Medicare Part B Resident in Medicare-certified part of a SNF	*Yes*	*No*
Medicare Part B *Not a Resident in Medicare-certified part of a SNF*	*No*	*Yes*

- *A hospital may not send therapy staff to provide therapy services in non-residential health care settings and bill for the services as if they were provided at the hospital, even if the hospital owns the other facility or entity. Examples of such non-residential settings include Comprehensive Outpatient Rehabilitation Facilities (CORFs), Rehabilitation Agencies, Outpatient Rehabilitation Facilities and offices of physicians or other practitioners, such as physical therapists. For example, services furnished to patients of a CORF must be billed as CORF services and not as outpatient hospital services. Even if a CORF contracts with a hospital to furnish services to CORF patients, the hospital may not bill Medicare for the services as hospital outpatient services. However, the CORF could have the hospital furnish services to its patients under arrangements, in which case the CORF would bill for the services.*

Psychiatric hospitals are treated the same as other hospitals for the purpose of therapy billing.