CMS Supervision Requirements for Rehabilitation Services in Hospital Settings

Medicare Personnel Qualifications for: **Occupational therapists** **Occupational therapy assistants** **Physical therapists** **Physical therapy assistants** **Speech-Language Pathologists**	**42CFR484.4 Personnel qualifications.** Staff required to meet the conditions set forth in this part are staff who meet the qualifications specified in this section. **Occupational therapist.** A person who: (a) Is a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or (b) Is eligible for the National Registration Examination of the American Occupational Therapy Association; or (c) Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapist after December 31, 1977. **Occupational therapy assistant.** A person who: (a) Meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association; or (b) Has 2 years of appropriate experience as an occupational therapy assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977. **Physical therapist.** A person who is licensed as a physical therapist by the State in which practicing, and (a) Has graduated from a physical therapy curriculum approved by: (1) The American Physical Therapy Association, or (2) The Committee on Allied Health Education and Accreditation of the American Medical

	Association, or (3) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or (b) Prior to January 1, 1966, (1) Was admitted to membership by the American Physical Therapy Association, or (2) Was admitted to registration by the American Registry of Physical Therapist, or (3) Has graduated from a physical therapy curriculum in a **4**-year college or university approved by a State department of education; or (c) Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or (d) Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy; or (e) If trained outside the United States, (1) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy. (2) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, **Physical therapy assistant.** A person who is licensed as a physical therapy assistant, if applicable, by the State in which practicing, and (1) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or (2) Has 2 years of appropriate experience as a physical therapy assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant

	after December 31, 1977. **Speech-language pathologist.** A person who: (1) Meets the education and experience requirements for a Certificate of Clinical Competence in (speech pathology or audiology) granted by the American Speech-Language-Hearing Association; or (2) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.
Medicare Definitions of Supervision Attributed to Rehabilitation Therapy Services	**42CFR410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.** (b) Diagnostic x-ray and other diagnostic tests (3) **Levels of supervision.** (i) **General supervision means** the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. (ii) **Direct supervision in the office setting means** the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed. (iii) **Personal supervision means** a physician must be in attendance in the room during the performance of the procedure.

CMS Supervision Requirements for Rehabilitation Services in Hospital Settings

Medicare Levels of Supervision Required in Inpatient Hospital Settings	**42CFR409.32 Criteria for skilled services and the need for skilled services.** (a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only **by, or under the supervision of**, professional or technical personnel. (b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in Sec. 409.33(d)) may be considered skilled because it must be **performed or supervised by** skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes. (c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in Sec. 409.33. **42CFR409.33 Examples of skilled nursing and rehabilitation services.** (a) Services that could qualify as either skilled nursing or skilled rehabilitation services--(1) Overall management and evaluation of care plan. (i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel. (ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other

	services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided. (2) Observation and assessment of the patient's changing condition-- (i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized. (ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes. (3) Patient education services--(i) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

	(ii) Examples. A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions. (c) Services which would qualify as skilled rehabilitation services. (1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; (2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be **performed by or under the supervision** of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment; (3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; (4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored); (5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning. (6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist; (7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and (8) Services of a speech pathologist or audiologist when necessary for the restoration of function

	in speech or hearing. (d) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in Sec. 409.32(b). Personal care services include, but are not limited to, the following: (1) Administration of routine oral medications, eye drops, and ointments; (2) General maintenance care of colostomy and ileostomy; (3) Routine services to maintain satisfactory functioning of indwelling bladder catheters; (4) Changes of dressings for noninfected postoperative or chronic conditions; (5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems; (6) Routine care of the incontinent patient, including use of diapers and protective sheets; (7) General maintenance care in connection with a plaster cast; (8) Routine care in connection with braces and similar devices; (9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator; (10) Routine administration of medical gases after a regimen of therapy has been established; (11) Assistance in dressing, eating, and going to the toilet; (12) Periodic turning and positioning in bed; and (13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services. **CMS Pub. 10 Hospital Manual** **Sec. 210.8 <u>Physical Therapy Furnished by the Hospital or by Others under Arrangements with the Hospital and under its Supervision</u>.--**

	A. General.--To be covered physical therapy services the services must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the individual's illness or injury. B. Reasonable and Necessary.--To be considered reasonable and necessary the following conditions must be met: (a) the services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition, (b) 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 qualified physical therapist or under his supervision**. Services which do not require the **performance or supervision of a physical therapist** are not considered reasonable or necessary physical therapy services, even if they are **performed or supervised by a physical therapist**. (When the intermediary determines the services furnished were of a type that could have been safely and effectively **performed only by a qualified physical therapist or under his supervision**, it will presume that **such services were properly supervised**. However, this assumption is rebuttable and if in the course of processing claims, the intermediary finds that physical therapy services are not being furnished under **proper supervision**, the intermediary will deny the claim and bring this matter to the attention of the Division of Survey and Certification of the HCFA regional office.) (c) there must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and (d) the amount, frequency, and duration of the services must be reasonable. NOTE: Claims for physical therapy services denied because they are not considered reasonable and necessary are excluded by section 1862(a)(1) and are thus subject to consideration under the waiver of liability provisions in section 1879 of the Act. (See §§291ff.) 1. Restorative Therapy.--To constitute physical therapy a service must, among other things, be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy

	services required to achieve such potential the physical therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. However, if at any point in the treatment of an illness it is determined that the expectations will not materialize, the services will no longer be considered reasonable and necessary; and they, therefore, should be excluded from coverage under section 1862(a)(1). 2. Maintenance Program.--The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, in certain instances the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to maintain the patient's present functional level. In such situations the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel, e.g., aids or nursing personnel (or family members where physical therapy is being furnished on an outpatient basis) in carrying out the program and such infrequent on an outpatient basis) in carrying out the program and such infrequent reevaluations as may be required would constitute physical therapy. Where a patient has been under a restorative physical therapy program, the physical therapist should regularly be reevaluating the condition and adjusting any exercise program in which the patient is engaged. Consequently, when it is determined that no further restoration is possible, the physical therapist should have already designed the maintenance program required and instructed the patient, supportive personnel (or family members where physical therapy is being furnished on an outpatient basis) in the carrying out of the program. Therefore, when a maintenance program is not established until after the restorative physical therapy program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under §1862(a)(l). C. Application of Guidelines.--The following discussion illustrates the application of the above

	guidelines to the more common modalities and procedures utilized in the treatment of patients: 1. Hot Pack, Hydrocollator, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths.--Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case the skills, knowledge, and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service. 2. Gait Training.--Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified physical therapist. However, if gait evaluation and training cannot reasonably be expected to improve significantly the patient's ability to walk, such services would not be considered reasonable and necessary. Repetitious exercises to improve gait or maintain strength and endurance and assistive walking, such as provided in support for feeble or unstable patients are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a qualified physical therapist. 3. Ultrasound, Shortwave, and Microwave Diathermy Treatments.--These modalities must always be **performed by or under the supervision of a qualified physical therapist** and therefore such treatments constitute physical therapy. 4. Range of Motion Tests.--Only the qualified physical therapist may perform range of motion tests and, therefore, such tests would constitute physical therapy. 5. Therapeutic Exercises.--Therapeutic exercises which **must be performed by or under the supervision of the qualified physical therapist or by a qualified physical therapy assistant under the general supervision of a qualified physical therapist** due either to the type of exercise employed or to the condition of the patient would constitute physical therapy. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored) and such exercises, either because of their nature or the condition of the patient, may only be **performed safely and effectively by or under the supervision of a qualified physical therapist**. Generally, range of motion exercises which are not related to the restoration of a specific loss of function but

rather are related to the maintenance of function (see B.2.) do not require the skills of a qualified physical therapist. However, such services may, under some circumstances, be included in the physical therapy cost center. (See §210.8D.)

D. Routine Services.--Many hospital inpatients who do not require physical therapy services do require services involving procedures which are routine in nature in the sense that they can be rendered by supportive personnel, e.g., aides or nursing personnel, without the supervision of a qualified physical therapist. Such services as well as services involving activities to promote over-all fitness and flexibility and activities to provide diversion or general motivation can be reimbursed through the physical therapy cost center even though they do not constitute physical therapy for Medicare purposes, if:

1. the services are medically necessary,
2. the treatment furnished is prescribed by a physician.
3. all services are provided by salaried employees of the physical therapy department of the provider,
4. the cost incurred is reasonable in amount (i.e., the employees' salaries are reasonably related to the level of skill and experience required to perform the services in question), and
5. charges are equally imposed on all patients.

If all of the above conditions are met, routine restorative services can be billed as ancillary physical therapy services and their costs included in the physical therapy cost center for reimbursement purposes.

The services furnished beneficiaries must constitute physical therapy where the entitlement to benefits is at issue. Since the outpatient physical therapy benefit under Part B provides coverage only of physical therapy services, payment can be made only for those services which constitute physical therapy.

Sec. 210.9 Occupational Therapy Furnished by the Hospital or by Others Under Arrangements with the Hospital and Under its Supervision.--

A. General.--Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individuals' ability to perform those

	tasks required for independent functioning. Such therapy may involve: 1. the evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests; 2. the selection and teaching of task-oriented therapeutic activities designed to restore physical function, e.g., use of wood-working activities on an inclined table to restore shoulder, elbow and wrist range of motion lost as a result of burns; 3. the planning, implementing, **and supervising of** individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness, e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient; 4. the planning and implementing of therapeutic tasks and activities to restore sensory-integrative function, e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image; 5. the teaching of compensatory technique to improve the level of independence in the activities of daily living, for example: o teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand. o teaching an upper extremity amputee how to functionally utilize a prosthesis. o teaching a stroke patient new techniques to enable him to perform feeding, dressing and other activities as independently as possible. o teaching a hip fracture/hip replacement patient techniques of standing tolerance and balance to enable him or her to perform such functional activities as dressing and homemaking tasks. 6. the designing, fabricating, and fitting of orthotic and self-help devices, e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed himself independently; and 7. vocational and prevocational assessment and training. Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for

	lost function and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate the patient's level of function and develop a plan of treatment, the implementation of the plan may also be carried out by a qualified **occupational therapy assistant functioning under the general supervision of the qualified occupational therapist. ("General supervision" requires initial direction and periodic inspection of the actual activity; however, the supervisor need not always be physically present or on the premises when the assistant is performing services.)** B. Coverage Criteria.--To constitute covered occupational therapy for Medicare purposes the services furnished to a beneficiary must be (1) prescribed by a physician, (2) **performed by a qualified occupational therapist or a qualified occupational therapy assistant under the general supervision of a qualified occupational therapist**, and (3) reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time. Where an individual's improvement potential is insignificant in relation to the extent and duration of occupational therapy services required to achieve improvement, such services would not be considered reasonable and necessary and would thus be excluded from coverage by 1862(a)(1). Where a valid expectation of improvement exists at the time the occupational therapy program is instituted, the services would be covered even though the expectation may not be realized. However, in such situations the services would be covered only up to the time at which it would have been reasonable to conclude that the patient is not going to improve. Once a patient has reached the point where no further significant practical improvement can be expected, the skills of an occupational therapist or occupational therapy assistant will not be required in the carrying out of any activity and/or exercise program required to maintain function at the level to which it has been restored. Consequently, while the services of an occupational therapist in designing a maintenance program and making infrequent but periodic evaluation of its effectiveness would be covered, the services of an occupational therapist or occupational therapy assistant in carrying out the program are not considered reasonable and necessary for the treatment of illness or injury and such services are excluded from coverage under section 1862(a)(1). Generally speaking, occupational therapy is not required to effect improvement or restoration of

	function where a patient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bed rest following major abdominal surgery) which could reasonably be expected to spontaneously improve as the patient gradually resumes normal activities. Accordingly, occupational therapy furnished in such situations would not be considered reasonable and necessary for the treatment of the individual's illness or injury and the services would be excluded from coverage by 1862(a)(1). Occupational therapy may also be required for a patient with a specific diagnosed psychiatric illness. Where such services are required they would be covered, assuming the coverage criteria set forth above are met, However, it should be noted that where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Rather, such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient, patient motivation being an appropriate and inherent function of all health disciplines which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist or occupational therapy assistant are not required, an occupational therapy program for such individuals would not be considered reasonable and necessary for the treatment of an illness or injury, and services furnished under such a program would be excluded from coverage by 1862(a)(1). See D for discussion regarding coverage of patient activity programs. As indicated, occupational therapy includes vocational and prevocational assessment and training. When services provided by an occupational therapist or assistant are related solely to specific employment opportunities, work skills or work settings, they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are excluded from coverage under the program by 1862(a)(1). However, care should be exercised in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and nonvocational purposes. For example, an assessment of sitting and standing tolerance might be nonvocational for a mother of young children or a retired individual living alone, but would be a vocational test for a sales clerk. Training an amputee in the use of a prosthesis for telephoning is necessary for every-day activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability; the techniques of adjustment cannot be considered exclusively vocational or nonvocational.

C. Supplies.--Occupational therapy frequently necessitates the use of various supplies, e.g., looms, ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center.

D. Patient Activity Programs.--In the inpatient hospital setting, organized patient activity programs are utilized to provide diversion and general motivation to inpatients. Although occupational therapists and occupational therapy assistants may be involved in directing and supervising such programs, these activity programs are part of a generalized effort directed to the health and welfare of all patients and such programs do not constitute occupational therapy and no ancillary charges may be recognized for such services. However, since these programs do constitute an integral part of good inpatient care they would be considered covered services related to the routine care of patients, providing: (1) the program is one ordinarily furnished by the hospital to its inpatients, and (2) it is of a type in which Medicare patients requiring a covered level of hospital care may reasonably be expected to participate. For example, patients requiring the level of hospital care covered under the program might engage in games such as checkers or chess, handicrafts such as sewing or weaving, and they might attend movies, etc. But, it would not be expected that such patients would be able to go on field trips, engage in strenuous athletics, or participate in other activities which are inappropriate for patients requiring the level of care covered under the program. (Of course, the capacities of physically healthy psychiatric patients would vary from those of patients whose ailments are physical.)

Sec. 210.11 Speech Pathology Services Furnished by Hospital or by Others Under Arrangements with Hospital and Under Its Supervision.--

A. General.--Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See Coverage Issues Manual, §35-89.) They must relate directly and specifically to a written treatment regimen established by the physician after any needed consultation with the qualified speech pathologist.

B. Reasonable and Necessary.--Speech pathology services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary, the

following conditions must be met:

o The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;

o The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only **by or under the supervision of a qualified speech pathologist**. (See 42 CFR 405.1202(u)(1)(2).) (When the intermediary determines the services furnished were of a type that could have been safely and effectively **performed only by qualified speech pathologists or under the supervision of a qualified speech pathologist**, it presumes that such services were **properly supervised**. However, this assumption is rebuttable and, if in the course of processing claims the intermediary finds that speech pathology services are not being furnished under **proper supervision**, the intermediary denies the claim and brings this matter to the attention of the Division of Health Standards and Quality of the RO.);

o There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment by the physician of the patient's restoration potential after any needed consultation with the qualified speech pathologist, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and

4. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. (The intermediary should consult with local speech pathologists or the State chapter of the American Speech- Language-Hearing Association in the development of any utilization guidelines.)

Claims for speech pathology services which are not reasonable and necessary should be considered denied under authority of section 1862(a)(1) and, therefore, are subject to the waiver of liability provisions in section 1879 of the Act. (See 287ff.)

C. Application of Guidelines.--The following discussion illustrates the application of the above guidelines to the more common situations in which the reasonableness and necessity of speech services furnished is a significant issue.

1. Restorative Therapy.--If an individual's expected restoration potential would be insignificant in relation to the extent and duration of speech pathology services required to achieve such potential, the services would not be considered reasonable and necessary. In addition, there

	must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness or injury it is determined that the expectations will not materialize, the services will no longer constitute covered speech pathology services, as they would no longer be reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1). 2. Maintenance Program.--After the initial evaluation of the extent of the disorder or illness, if the restoration potential is judged insignificant or, after a reasonable period of trial, the patient's response to treatment is judged insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified speech pathologist may be required if the treatment aim of the physician is to be achieved; e.g., a multiple sclerosis patient may require the services of a speech pathologist to establish a maintenance program designed to fit the patient's level of function. In such a situation, the initial evaluation of the patient's needs, the designing by the qualified speech pathologist of the maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient and supportive personnel (e.g., aides or nursing personnel, or family members where speech pathology is being furnished on an outpatient basis) in carrying out the program, and such infrequent reevaluations as may be required, would constitute covered speech therapy. After the maintenance program has been established and instructions have been given for carrying out the program, the services of the speech pathologist would no longer be covered, as they would no longer be considered reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1). If a patient has been under a restorative speech pathology program, the speech pathologist should regularly reevaluate the condition and adjust the treatment program. Consequently, during the course of treatment the speech pathologist should determine when the patient's restorative potential will be achieved and, by the time the restorative program has been completed, should have designed the maintenance program required and instructed the patient, supportive personnel, or family members in the carrying out of the program. A separate charge for the establishment of the maintenance program under these circumstances would not be recognized. Moreover, where a maintenance program is not established until after the restorative speech pathology program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1) since the

maintenance program should have been established during the active course of treatment.

D. Types of Services.--Speech pathology services can be grouped into two main categories: services concerned with diagnosis or evaluation and therapeutic services.

1. Diagnostic and Evaluation Services.--Unless excluded by section 1862(a)(7) of the law, these services are covered if they are reasonable and necessary. The speech pathologist employs a variety of formal and informal language assessment tests to ascertain the type, causal factor(s), and severity of the speech and language disorders. Reevaluation would be covered only if the patient exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated speech pathology. However, monthly reevaluations, e.g., a Porch Index of Communicative Ability (PICA) for a patient undergoing a restorative speech pathology program, are considered a part of the treatment session and are not covered as a separate evaluation for billing purposes.

2. Therapeutic Services.--The following are examples of common medical disorders and resulting communication deficits which may necessitate active restorative therapy:

- o Cerebrovascular disease such as cerebral, vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;
- o Neurological disease such as Parkinsonism or Multiple Sclerosis may exhibit dysarthria, dysphagia, or inadequate respiratory volume/control;
- o Mental retardation with disorders such as aphasia or dysarthria; and
- o Laryngeal carcinoma requiring laryngectomy resulting in aphonia may warrant therapy of the laryngectomized patient so he/she can develop new communication skills through esophageal speech and/or use of the electrolarynx.

NOTE: Many patients who do not require speech pathology services as defined do require services involving nondiagnostic, nontherapeutic, routine, repetitive, and reinforced procedures or services for their general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicare purposes and are not covered since they do not require performance by or the supervision of a qualified speech pathologist.

CMS PUB. 13 Intermediary Manual

3101.8 Physical Therapy Furnished by the Hospital or by Others under Arrangements with

	the Hospital and under its Supervision.-- A. Definition.-- To constitute physical therapy services, the services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively **performed only by a qualified physical therapist or under his supervision**. When the intermediary determines the services furnished were of a type that could have been safely and effectively performed only **by a qualified physical therapist or under his supervision**, it should presume that such services were **properly supervised**. B. Reasonable and Necessary.-- To be reimbursable physical therapy must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary the following conditions must be met: (a) The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition, (b) There must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and (c) The amount, frequency, and duration of the services must be reasonable. Claims for physical therapy services denied because they are not considered reasonable and necessary under section 1862(a)(1) should be considered under the waiver of liability provision in § 1879 of the act. (See §§ 3430ff.). l. Restorative Therapy.-- To constitute physical therapy a service must, among other things, be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential the physical therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness it is determined that the expectations will not materialize the services will no

	longer be considered reasonable and necessary. 2. Maintenance Program.-- The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, in certain instances the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to maintain his present functional level. In such situations the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel, e.g., aids or nursing personnel (or family members where physical therapy is being furnished on an outpatient basis) in carrying out the program and such infrequent reevaluations as may be required would constitute physical therapy. Where a patient has been under a restorative physical therapy program, the physical therapist should regularly be reevaluating the condition and adjusting any exercise program in which the patient is engaged. Consequently, when it is determined that no further restoration is possible, the physical therapist should have already designed the maintenance program required and instructed the patient, supportive personnel (or family members where physical therapy is being furnished on an outpatient basis) in the carrying out of the program. Therefore, where a maintenance program is not established until after the restorative physical therapy program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under § 1862 (a)(1). C. Application of Guidelines.-- The following discussion illustrates the application of the above guidelines to the more common modalities and procedures utilized in the treatment of patients: 1. Hot Pack, Hydrocollator, Infra-Red Treatments and Whirlpool Bath.-Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case the skills, knowledge, and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they

	would be considered part of the physical therapy service. 2. Gait Training.--Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a qualified physical therapist. However, if gait evaluation and training cannot reasonably be expected to improve significantly the patient's ability to walk, such services would not be considered reasonable and necessary. Repetitious exercises to improve gait or maintain strength and endurance and assisted walking, such as provided in support for feeble or unstable patients are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a qualified physical therapist 3. Ultrasound, Shortwave, and Microwave Diathermy Treatments.--These modalities must always be **performed by or under the supervision** of a qualified physical therapist and therefore such treatments constitute physical therapy. 4. Range of Motion Tests.--Only the qualified physical therapist may perform range of motion tests and, therefore, such tests would constitute physical therapy. 5. Therapeutic Exercises.--Therapeutic exercises which must be performed **by or under the supervision of the qualified physical therapist or by a qualified physical therapist** due either to the type of exercise employed or to the condition of the patient would constitute physical therapy. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored) and such exercises, either because of their nature on the condition of the patient, may only be performed safely and effectively **by or under the supervision of a qualified physical therapist**. Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function (see B.2.) do not require the skills of a qualified physical therapist. However, such services may, under some circumstances, be included in the physical therapy cost center. (See Section 3101.8(D). D. Routine Services.--Many hospital inpatients who do not require physical therapy services as defined in Section 3101.8A above do require services involving procedures which are routine in nature in the sense that they can be rendered by supportive personnel, e.g., aids or nursing personnel, without the supervision of a qualified physical therapist. Such services as well as services involving activities to promote over-all fitness and flexibility and activities to provide diversion or general

	motivation can be reimbursed through the physical therapy cost center even though they do not constitute physical therapy for Medicare proposes, if: 1. The services are medically necessary, 2. The treatment furnished is prescribed by a physician, 3. All services are provided by salaried employees of the physical therapy department of the provider, 4. The cost incurred is reasonable in amount (i.e., the employees' salaries are reasonably related to the level of skill and experience required to perform the services in question), and 5. Charges are equally imposed on all patients. If all of the above conditions are met, routine restorative services can be billed as ancillary physical therapy services and their costs included in the physical therapy cost center for reimbursement purposes. The services furnished beneficiaries must meet the definition of physical therapy where the entitlement to benefits is at issue. Since the outpatient physical therapy benefit under Part B provides coverage only of physical therapy services, payment can be made only for the services which constitute physical therapy. **3101.9 <u>Occupational Therapy Furnished by the Hospital or by Others under Arrangements with the Hospital and under its Supervision</u>.--** A. <u>General</u>.--Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve: 1. The evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests; 2. The selection and teaching of task-oriented therapeutic activities designed to restore physical function, e.g., use of woodworking activities on an inclined table to restore shoulder, elbow and wrist range of motion lost as a result of burns; 3. The planning, implementing, **and supervising of individualized therapeutic activity programs** as part of an overall "active treatment" program for a patient with a diagnosed psychiatric

	illness, e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient; 4. The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function, e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image; 5. The teaching of compensatory technique to improve the level of independence in the activities of daily living, for example: o Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand; o Teaching an upper extremity amputee how to functionally utilize a prosthesis; o Teaching a stroke patient new techniques to enable him to perform feeding, dressing and other activities as independently as possible; and o Teaching a hip fracture/hip replacement patient techniques of standing tolerance and balance to enable him or her to perform such functional activities as dressing and homemaking tasks. 6. The designing, fabricating, and fitting of orthotic and self- help devices, e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed himself independently; and 7. Vocational and prevocational assessment and training. Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate the patient's level of function and develop a plan of treatment, the **implementation of the plan may also be carried out by a qualified occupational therapy assistant functioning under the general supervision of the qualified occupational therapist**. (**"General supervision" requires initial direction and periodic inspection of the actual activity; however, the supervisor need not always be physically present or on the premises when the assistant is performing services).** B. Coverage Criteria.--To constitute covered occupational therapy for Medicare purposes the

	services furnished to a beneficiary must be (l) prescribed by a physician, (2) **performed by a qualified occupational therapist or a qualified occupational therapy assistant under the general supervision of a qualified occupational therapist**, and (3) reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time. Where an individual's improvement potential is insignificant in relation to the extent and duration of occupational therapy services required to achieve improvement, such services would not be considered reasonable and necessary and would thus be excluded from coverage by l862(a)(l). Where a valid expectation of improvement exists at the time the occupational therapy program is instituted, the services would be covered even though the expectation may not be realized. However, in such situations the services would be covered only up to the time at which it would have been reasonable to conclude that the patient is not going to improve. Once a patient has reached the point where no further significant practical improvement can be expected, the skills of an occupational therapist or occupational therapy assistant will not be required in the carrying out of any activity and/or exercise program required to maintain function at the level to which it has been restored. Consequently, while the services of an occupational therapist in designing a maintenance program and making infrequent but periodic evaluation of its effectiveness would be covered, the services of an occupational therapist or occupational therapy assistant in carrying out the program are not considered reasonable and necessary for the treatment of illness or injury and such services are excluded from coverage under section l862(a)(l). Generally speaking, occupational therapy is not required to effect improvement or restoration of function where a patient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bedrest following major abdominal surgery) which could reasonably be expected to spontaneously improve as the patient gradually resumes normal activities. Accordingly, occupational therapy furnished in such situations would not be considered reasonable and necessary for the treatment of the individual's illness or injury and the services would be excluded from coverage by 1862(a)(1). Occupational therapy may also be required for a patient with a specific diagnosed psychiatric illness. Where such services are required they would be covered, assuming the coverage criteria set forth

	above are met. However, it should be noted that where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Rather, such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient, patient motivation being an appropriate and inherent function of all health disciplines which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist or occupational therapy assistant are not required, an occupational therapy program for such individuals would not be considered reasonable and necessary for the treatment of an illness or injury, and services furnished under such a program would be excluded from coverage by 1862(a)(1). See D for discussion regarding coverage of patient activity programs. As indicated, occupational therapy includes vocational and prevocational assessment and training. When services provided by an occupational therapist and/or assistant are related solely to specific employment opportunities, work skills or work settings, they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are excluded from coverage under the program by 1862(a)(1). However, care should be exercised in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and nonvocational purposes. For example, an assessment of sitting and standing tolerance might be nonvocational for a mother of young children or a retired individual living along, but would be a vocational test for a sales clerk. Training an amputee in the use of a prosthesis for telephoning is necessary for every-day activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability; the techniques of adjustment cannot be considered exclusively vocational or nonvocational. C. Supplies.--Occupational therapy frequently necessitates the use of various supplies, e.g., looms, ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center. However, to prevent possible abuse in this area these costs should be carefully reviewed by the intermediary to ensure that they are reasonable. D. Patient Activity Programs.--In the inpatient setting, organized patient activity programs are utilized to provide diversion and general motivation to inpatients. Although occupational therapists and occupational therapy assistants may be involved in directing and supervising such programs, these activity programs are part of a generalized effort directed to the health and welfare of all

	patients and such program do not constitute occupational therapy and no ancillary charges may be recognized for such services. However, since these programs do constitute an integral part of good inpatient care they would be considered covered services related to the routine care of patients, providing: (l) the program is one ordinarily furnished by the provider to its inpatients, and (2) it is of a type in which Medicare patients requiring a covered level of inpatient care may reasonably be expected to participate. For example, patients requiring the level of inpatient care covered under the program might engage in games such as checkers or chess, handicrafts such as sewing or weaving, and they might attend movies, etc. But, it would not be expected that such patients would be able to go on field trips, engage in strenuous athletics, or participate in other activities which are inappropriate for patients requiring the level of care covered under the program. (The capacities of physically healthy psychiatric patients would vary from those of patients whose ailments are physical). **3101.10A. Speech Pathology Services Furnished by Hospital or by Others Under Arrangements with Hospital and Under Its Supervision.—** 1. General.--Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See Coverage Issues Manual, §35-89.) They must relate directly and specifically to a written treatment regimen established by the physician after any needed consultation with the qualified speech pathologist. 2. Reasonable and Necessary.--Speech pathology services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary, the following conditions must be met: o The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition; o The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively **performed only by or under the supervision of a qualified speech pathologist**. (See 42 CFR 405.l202(u)(l)(2).) (When you determine the services furnished were of a type that could have been safely and

	effectively **performed only by qualified speech pathologists or under the supervision of a qualified speech pathologist**, presume that such services were **properly supervised**. However, this assumption is rebuttable and, if in the course of processing claims you find that speech pathology services are not being furnished under proper supervision, deny the claim and bring this matter to the attention of the Division of Health Standards and Quality of the RO.); o There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment by the physician of the patient's restoration potential after any needed consultation with the qualified speech pathologist, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and o The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. (Consult with local speech pathologists or the State chapter of the American Speech-Language-Hearing Association in the development of any utilization guidelines.) Claims for speech pathology services which are not reasonable and necessary are denied under authority of §1862(a)(1) and, therefore, are subject to the waiver of liability provisions in §1879 of the Act. (See 3430ff.) 3. Application of Guidelines.--The following discussion illustrates the application of the above guidelines to the more common situations in which the reasonableness and necessity of speech services furnished is a significant issue. a. Restorative Therapy.--If an individual's expected restoration potential would be insignificant in relation to the extent and duration of speech pathology services required to achieve such potential, the services would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness or injury it is determined that the expectations will not materialize, the services will no longer constitute covered speech pathology services, as they would no longer be reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section l862(a)(l). b. Maintenance Program.--After the initial evaluation of the extent of the disorder or illness, if the restoration potential is judged insignificant or, after a reasonable period of trial, the patient's response to treatment is judged insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified speech

	pathologist may be required if the treatment aim of the physician is to be achieved; e.g., a multiple sclerosis patient may require the services of a speech pathologist to establish a maintenance program designed to fit the patient's level of function. In such a situation, the initial evaluation of the patient's needs, the designing by the qualified speech pathologist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient and supportive personnel (e.g., aides or nursing personnel, or family members where speech pathology is being furnished on an outpatient basis) in carrying out the program, and such infrequent reevaluations as may be required, would constitute covered speech therapy. After the maintenance program has been established and instructions have been given for carrying out the program, the services of the speech pathologist would no longer be covered, as they would no longer be considered reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1). If a patient has been under a restorative speech pathology program, the speech pathologist should regularly reevaluate the condition and adjust the treatment program. Consequently, during the course of treatment the speech pathologist should determine when the patient's restorative potential will be achieved and, by the time the restorative program has been completed, should have designed the maintenance program required and instructed the patient, supportive personnel, or family members in the carrying out of the program. A separate charge for the establishment of the maintenance program under these circumstances would not be recognized. Moreover, where a maintenance program is not established until after the restorative speech pathology program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1) since the maintenance program should have been established during the active course of treatment. 4. Types of Services.--Speech pathology services can be grouped into two main categories: services concerned with diagnosis or evaluation and therapeutic services. a. Diagnostic and Evaluation Services.--Unless excluded by section 1862(a)(7) of the law, these services are covered if they are reasonable and necessary. The speech pathologist employs a variety of formal and informal language assessment tests to ascertain the type, causal factor(s), and severity of the speech and language disorders. Reevaluation would be covered only if the patient exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated speech pathology. However,

	monthly reevaluations, e.g., a Porch Index of Communicative Ability (PICA) for a patient undergoing a restorative speech pathology program, are to be considered a part of the treatment session and could not be covered as a separate evaluation for billing purposes. b. Therapeutic Services.--The following are examples of common medical disorders and resulting communication deficits which may necessitate active restorative therapy: (i) Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria; (ii) Neurological disease such as Parkinsonism or Multiple Sclerosis may exhibit dysarthria, dysphagia, or inadequate respiratory volume/control; (iii) Mental retardation with disorders such as aphasia or dysarthria; and (iv) Laryngeal carcinoma requiring laryngectomy resulting in aphonia may warrant therapy of the laryngectomized patient so he can develop new communication skills through esophageal speech and/or use of the electrolarynx. NOTE: Many patients who do not require speech pathology services as defined above do require services involving nondiagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services for their general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicare purposes and would not be covered since they do not require performance by or the supervision of a qualified speech pathologist.