
Medicare

Outpatient Physical Therapy

Comprehensive Outpatient Rehabilitation Facility and Community Mental Health Center Manual

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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
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This revision manualizes Program Memorandum (PM) A-99-39, Change Request 882, dated September 1999.

MANUALIZATION--EFFECTIVE/IMPLEMENTATION DATE: Not Applicable

Section 260.1, General, provides a general description of the program of services which make up the partial hospitalization services benefit in order to be covered under the Medicare benefit.

Section 260.4, Partial Hospitalization Defined, manualizes the more detailed description of partial hospitalization found in PM A-99-39. It provides an overview of what is considered active treatment necessary to meet the requirements of a PHP and replaces the old 260.5

Section 260.5, Patient Eligibility Criteria, is new material and manualizes the criteria from PM A-99-39 describing the statutory requirements a patient must meet to be eligible to receive partial hospitalization services under the Medicare benefit.

Section 260.6, Documentation Requirements and Physician Supervision, incorporates part of the old 260.7 as well as describes what the contents of a patient's medical record should include to receive payment for the partial hospitalization benefit.

Section 260.7, Noncovered Services, is being **deleted**.

**NEW/REVISED MATERIAL--EFFECTIVE DATE: October 16, 2000
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Section 260.2, CMHC Requirements, is new and revised material, consistent with the State Operations Manual, describing HCFA's guidelines for CMHCs to meet the Public Health Service Core Service requirements to participate in the Medicare program as a provider of partial hospitalization services. It also clarifies requirements for core services provided under arrangement.

Section 260.3, Outpatient Mental Health Treatment Limitation, is the old 260.4.

Section 260.6, Documentation Requirements and Physician Supervision, adds new material contained in the Medicare Prospective Payment System for Hospital Outpatient PHP physician recertification requirements (HCFA 1005FC, 42 CFR 424.24(e)).

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted

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EXAMPLE 2: Mr. Smith, who has chronic schizophrenia, was injured in an accident resulting in amputation of his right hand and foot. Following a period of hospitalization, during which he was fitted with an artificial hand and foot, he was referred to the CORF for physical therapy, occupational therapy, and social services. Even though Mr. Smith has a psychiatric condition, the CORF services are not furnished in connection with that condition and are not subject to the limitation.

EXAMPLE 3: Ms. Brown also has chronic schizophrenia and also was injured in an accident. She was referred to the CORF for the same services as Mr. Smith, except that after treatment was initiated, it was determined that her mental condition was aggravated by the results of the accident. Ms. Brown also needed psychological counseling, and the occupational therapy and social services were continued but revised to take into account her mental state. The physical therapy is not subject to the limitation. The psychological counseling is subject to the limitation. Because it cannot be clearly established whether the occupational therapy and social services are in connection with Ms. Brown's physical or mental problem, 50 percent of the customary charges for these services are subject the limitation.

EXAMPLE 4: Mr. Green had a leg amputated due to bone cancer. He was referred to the CORF for physical therapy. His progress has been hindered because he developed a severe depression triggered by his condition. The physical therapy is not subject to the limitation, but psychological treatment of the depression is subject to the limitation.

C. Computation of Limitation--Determine the customary charges for CORF services subject to the limitation. Multiply these customary charges by 0.625 to obtain the amount of expenses subject to the Part B deductible and 20 percent coinsurance.

The beneficiary is responsible for both the 37.5 percent reduction in customary charges and the deductible and coinsurance applied to the reduced charges. Once the deductible has been satisfied, a beneficiary is responsible for 50 percent of the customary charges, which is the sum of 37.5 percent plus 12.5 percent (20 percent of 0.625).

D. Expenses Incurred Before 1990--For calendar years before 1990, an additional limitation in the form of a fixed dollar cap is applied to these expenses. For expenses incurred by an individual during each calendar year, the maximum customary charge that could be recognized was:

1989	\$2200
1988	\$ 900
Each year before 1988	\$ 500

The annual cap applied to the combination of customary charges for CORF services and reasonable charges for physician services that were subject to the limitation.

Partial Hospitalization Services

260. PARTIAL HOSPITALIZATION SERVICES PROVIDED BY COMMUNITY MENTAL HEALTH CENTERS (CMHCs)

260.1 General.--OBRA 1990 amended §1861(ff)(3) of the Act to authorize CMHCs to provide partial hospitalization services under Medicare Part B, effective October 1, 1991.

PHPs are structured to provide intensive psychiatric care through active treatment which utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act. The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

260.2 CMHC Requirements.--

A. Licensing and Certification Requirements.--In order for you to be certified by Medicare as a CMHC, you must provide (either directly or under arrangement) the services specified in 1913(c)(1) of the Public Health Service Act and meet applicable licensing or certification requirements for CMHCs in the State in which it is located:

1. Outpatient Services.--Including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of your mental health service area who have been discharged from inpatient treatment at a mental health facility.

2. 24-Hour Emergency Care Services.--Twenty-four hour emergency care services must be available through a system that provides for access to a clinician and appropriate disposition with follow-up documentation of the emergency in the patient's CMHC medical record. A psychiatric emergency may occur at anytime, and a patient must have access to evaluation and stabilization services after normal business hours. A range of emergency interventions may be necessary and should be available to the patient, including a face-to-face interview, medication evaluation, and hospitalization. While hot lines, beepers, and answering services may be facets of emergency services, they may not constitute their totality.

3. Day Treatment or Other Partial Hospitalization or Psychosocial Rehabilitation Services.--These are structured treatment programs (less than 24-hour per day) that use a multidisciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services provided based on the needs of the patient. PHPs are structured to provide intensive psychiatric care while other types of day treatment programs tend to provide more supportive services. The Medicare benefit is for partial hospitalization services only. Coverage requirements for Medicare PHPs are specified in §260.5.

4. Screening for Patients Being Considered for Admission to State Mental Health Facilities to Determine the Appropriateness of Such Admission.--Screening constitutes the performance of at least one of the steps in a process by which an individual is clinically evaluated, pursuant to State law, for the appropriateness of admission to a State mental health facility by an entity that has both the appropriate clinical personnel and authorization under State law, to perform all of the steps in the clinical evaluation process except those required to be provided by a 24-hour facility. The screening must be for the specific purpose (e.g., reason for referral) of assessment of

the patient's need for admission to a State mental health facility. Where there are State requirements for the completion of required forms, court documents or any other required documentation in response to the screening request, these documents would be evidence of providing the service. Otherwise, evidence in the screening assessment must include a clinical decision regarding the appropriate level of care needed by the patient and follow-up placement.

B. Core Services Provided Under Arrangement.--A CMHC may provide one or more core services under arrangement with another individual, group, or entity only when the following criteria are met:

1. Service Authorized by State Law.--In no case may a CMHC provide a service under arrangement when the CMHC has not been given authority to provide the service itself directly under State statute, licensure, certification, or regulation.

2. Full Legal Responsibility.--A CMHC that provides a core service under arrangement remains the legally responsible authority through which comprehensive mental health services are provided. It is not sufficient for the arrangement to be a referral process where the CMHC does not assume overall management responsibility for the provision of core services by a separate individual, group, or entity. The CMHC must retain complete accountability for the service(s) provided under arrangement. The CMHC must retain legal, professional, and administrative responsibility to coordinate care, supervise, and evaluate the services, and ensure the delivery of high quality mental health treatment.

3. Written Agreement.--Arrangements must be in writing and accessible to HCFA and its agents. If a CMHC provides services under arrangement, there must be a written agreement or contract between the two parties that specifies the services to be rendered and the manner in which the CMHC exercises its professional and administrative responsibility. Furthermore, for the agreement to serve as the vehicle through which the CMHC meets the requirement to provide all of the core services, the terms of the agreement must be adhered to in practice. In order to verify the nature of the relationship between the CMHC and the other party, the agreement must be accessible to HCFA or its agents, and the documentation for all services rendered, whether directly or under arrangement, must be maintained by the CMHC at the site identified in the provider agreement.

C. Provider Agreement Requirements.--Section 1866(e)(2) of the Act recognizes CMHCs as providers of services for purposes of provider agreement requirements but only for the furnishing of partial hospitalization services. CMHCs are paid on the basis of their reasonable costs.

260.3 Outpatient Mental Health Treatment Limitation.--The outpatient mental health treatment limitation does not apply to partial hospitalization services that are not directly provided by a physician. (In other words, the limitation does apply to partial hospitalization services furnished by a physician.) Physicians and certain other allied health professionals (e.g., clinical psychologists) have the option to bill the Part B carrier directly or authorize you to bill the carrier on their behalf for their professional services in CMHCs. Any physician or allied health professional services that are billed to a carrier are not partial hospitalization services. When a carrier is billed for these professional services, the services are subject to the provisions of the outpatient mental health treatment limitation. Accordingly, Medicare payment is limited to 62.5% of the amount that would otherwise be paid under the physician fee schedule or the payment amount that would be due under the reasonable charge system.

260.4 Partial Hospitalization Defined.--PHPs work best as part of a community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served. PHPs may be covered under Medicare when they are provided by a hospital outpatient department or a Medicare-certified CMHC

Partial hospitalization is active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient, and includes a multidisciplinary team approach to patient care under the direction of a physician. The program reflects a high degree of structure and scheduling. According to current practice guidelines the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a PHP.

260.5 Patient Eligibility Criteria.--

A. **Benefit Category.**--Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization. The patient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature.

Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP. Recertification must address the continuing serious nature of the patient's psychiatric condition requiring active treatment in a PHP.

Discharge planning from PHP may reflect the types of best practices recognized by professional and advocacy organizations which ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.

B. **Covered Services.**--Items and services that can be included as part of the structured, multimodal active treatment program, identified in §1861(ff)(2) include:

o Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);

- o Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual;
- o Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;
- o Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);
- o Individualized activity therapies that are not primarily recreational or diversionary. (These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals);
- o Family counseling services for which the primary purpose is the treatment of the patient's condition;
- o Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition; and
- o Medically necessary diagnostic services related to mental health treatment.

Partial hospitalization services which make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).

C. Reasonable and Necessary Services.--This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization. A particular individual covered service (described above) as intervention, expected to maintain or improve the individual's condition and prevent relapse, may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Patients admitted to a PHP do not require 24-hour per day supervision as provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the PHP. Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association, which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition.

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

Patients in PHPs may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the patient's clinical condition improves or stabilizes and he/she no longer requires structured, intensive, multimodal treatment.

D. Reasons for Denial--

o Benefit category denials made under §1861(ff) or §1835(a)(2)(F) of the Act are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1). Examples of benefit category denials based in §1861(ff) or §1835(a)(2)(F) of the Act for partial hospitalization services generally include the following:

-- Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;

-- Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for the chronically mentally ill; or

-- Patients who are otherwise psychiatrically stable or require medication management only.

o Coverage denials made under §1861(ff) of the Act are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1). Examples of coverage denials based in §1861(ff) of the Act, excluded from the scope of partial hospitalization services, include the following:

-- Services to hospital inpatients;

-- Meals, self-administered medications, transportation; and

-- Vocational training.

o Reasonable and necessary denials based on §1862(a)(1)(A) of the Act are appealable and the Limitation on Liability provision does apply. Examples of reasonable and necessary denials for partial hospitalization services under §1862(a)(1)(A) of the Act, include the following:

-- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a PHP; or

-- Treatment of chronic conditions without acute exacerbation of symptoms which place the individual at risk of relapse or hospitalization.

260.6 Documentation Requirements and Physician Supervision.--The following components will be used to help determine whether the services provided were accurate and appropriate.

A. Initial Psychiatric Evaluation/Certification.--Upon admission, and periodically thereafter, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

B. Physician Recertification Requirements.--

o Signature - The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

o Timing - The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

o Content - The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:

- The patient's response to the therapeutic interventions provided by the PHP;
- The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization; and
- Treatment goals for coordination of services to facilitate discharge from the PHP.

C. Treatment Plan.--Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

D. Progress Notes.--Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan.

Outpatient Therapy Services

270. CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES

Outpatient physical therapy (PT), occupational therapy (OT), or speech pathology (SP) services furnished to a beneficiary by a participating provider are covered only when furnished in accordance with the following conditions.

270.1 Physician Certification and Recertification--

A. Content of Physician Certification--No payment may be made for outpatient PT, OT, or SP services unless a physician certifies that:

- o A plan for furnishing such services is or was established by the physician, physical therapist, occupational therapist, or speech pathologist and periodically reviewed by the physician (see §270.3);

- o The services are or were furnished while the patient was under the care of a physician (see §270.2); and

- o The services are or were reasonable and necessary to the treatment of the patient's condition.

Since the certification is closely associated with the plan of treatment, the same physician who establishes or reviews the plan must certify the necessity for the services. Obtain the certification at the time the plan of treatment is established or as soon thereafter as possible. A physician is a doctor of medicine, osteopathy, or podiatric medicine if the services are consistent with the function he/she is legally authorized to perform in the State in which he/she performs the function. The services performed by physicians within this definition are subject to any limitations imposed by the State on the scope of practice.

B. Recertification--When services are continued under the same plan of treatment, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and must estimate how long services are needed. Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. Recertifications are signed by the physician who reviews the plan of treatment. You may choose the form and manner of obtaining timely recertification.

C. Method and Disposition of Certifications--There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way, as long as the contractor can determine, when necessary, that the certification and recertification requirements are met. Retain certification by the physician and certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file when the request for payment is forwarded.

D. Delayed Certification--Obtain certifications and recertifications as promptly as possible. Payment is not made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications are to include an explanation for the delay and any other evidence necessary in the case. You may choose the form and manner of obtaining delayed certifications and recertifications.