



Last Piece of the Puzzle Series

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WHO CAN PROVIDE THERAPY FOR MY MEDICARE PATIENT?

This is probably one of our most frequent inquiries from non-client practices and one of the most frequent causes for patients to report their doctors to Medicare.

While other carriers may not be as strict, some, like the Union plans are even stricter with their policies.

It should be logical to the practitioner that the "payment" for therapy is based on the "skilled services" of the provider of the service. If the "service" can be performed by "anyone", it is illogical to call it a "skilled therapy service".

Under Medicare, the rules were made "perfectly clear" in the revisions to the "incident to" provisions.

Qualifications of Auxiliary Personnel.

Therapy services appropriately billed incident to a physician's /NPP's service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting *with one exception*. When therapy services are performed incident to a physician's/NPP's service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. Qualifications for therapists are found in 42CFR484.4 and in section 230.1, 230.2, and 230.3 of this manual.

In effect, these rules require that the person who furnishes the service to the patient must, *at least, be a graduate of a program of training for one of the therapy services* as described above.

Regardless of any state licensing that allows *other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy* or speech-language pathology. **That means that the services of *athletic trainers, massage therapists***, recreation therapists, kinesiotherapists, low vision specialists or any other profession *may not be billed as therapy services*.

- We made specific inquiry on the issue of a licensed massage therapist being permitted to perform "myofascial release techniques" under the direct supervision of the physical therapist and were informed that this IS NOT payable under the regulations. (According to CMS source) The language is clear in the regulations however most States now license Massage therapists and CMS "may" ease this at some time provided that the MT is under the direct supervision of the PT.

To be covered, services must be skilled therapy services as described in this chapter and be rendered under the conditions specified. Services provided by professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services. Services which do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions for therapy services.

The services of PTAs and OTAs also **may not** be billed incident to a physician's/NPP's service.

However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, **when directly supervised by the PT** or the services of the OTA, when directly supervised by the OT *may be billed by the physician group* as PT or OT services **using the PIN/NPI of the enrolled PT (or OT).**

If the PT or OT is not enrolled, Medicare shall not pay for the services of a PTA or OTA billed incident to the "physician's service", because they do not meet the qualification standards in 42CFR484.4.

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

THERAPIST refers **only** to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, (PT); 230.2 (OT), and 230.3 (SLP).

THERAPY, or outpatient rehabilitation services, includes **only** outpatient physical therapy, occupational therapy and speech-language pathology services paid using the Medicare Physician Fee Schedule.

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

To be considered reasonable and necessary the following conditions **must each be met**:

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a qualified therapist.

Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

*While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled.

The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.

- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is open for rebuttal, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.
- There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

NOTE: Claims for therapy services denied because they are not considered reasonable and necessary are excluded by §1862(a)(1) of the Act and are thus subject to consideration under the waiver of liability provision in §1879 of the Act.

Physical Therapist Defined: §203.1

Reference: 42CFR484.4

A qualified physical therapist for program coverage purposes is a person who is licensed as a physical therapist by the state in which he or she is practicing and meets one of the following requirements:

- Has graduated from a physical therapy curriculum approved by (1) the American Physical Therapy Association, or by (2) the Committee on Allied Health Education and Accreditation of the American Medical Association, or (3) Council on Medical Education of the American Medical Association, and the American Physical Therapy Association; or
- 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 Therapists, or (3) has graduated from a physical therapy curriculum in a 4-year college or university approved by a state department of education; or
- 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 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
- 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
- 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 Defined:

Reference: 42CFR 484.4

A physical therapist assistant (PTA) is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and

- Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or
- Has 2 years of appropriate experience as a physical therapist 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 PTA after December 31, 1977.

The services of PTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising physical therapist.

PTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws.

A physical therapist must supervise PTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings **except private practice** (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed.

The services of a PTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

Services provided by aides, even if under the supervision of a therapist, are not therapy services in the outpatient setting and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

Incident to a Therapist.

There is no coverage for services provided "incident to" the services of a therapist.

Although PTAs and OTAs work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the actual benefit for therapy services much like the services of a PA or NPP as an extender. Since the supervision requirements are limited to PT/OT over their respective assistants the performance responsibility falls to the PT/OT who has direct control and since the services are covered under a separate section of the Act, there is no provision for benefit of services incident to a physician/NPP.

Qualifications of Auxiliary Personnel.

Therapy services appropriately billed incident to a physician's/NPP's service shall be subject to the same requirements as therapy services that would be furnished by a therapist in any other outpatient setting with one exception. When therapy services are performed "incident to" a physician's/NPP's service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law.

The qualified personnel however must meet all the other requirements for a therapist. In effect, these rules require that the person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above.

Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized under the Act to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession **may not be billed as therapy services.**

The services of PTAs and OTAs may not be billed incident to a physician's/NPP's service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, when directly supervised by the PT or the services of the OTA, when directly supervised by the OT, may be billed by the physician group as PT or OT services using the PIN/NPI of the enrolled PT (or OT).

If the PT or OT is not enrolled, Medicare shall not pay for the services of the PTA or OTA because the PT/OT does not meet the qualification standards in 42CFR484.4 to supervise.

Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements in this manual in chapter 15, §60. Where the policies have different requirements, the more stringent requirement shall be met.

For example, when therapy services are billed as "incident to a physician/NPP services", the requirement for "direct supervision by the physician/NPP" and other incident to requirements must be met, even though the service is provided by a licensed therapist who may perform the services unsupervised in other settings.

We frequently get comments and argument from new clients that in most States a Chiropractor is permitted to perform physical therapy procedures. While this IS true under State law it is NOT compliant with Medicare regulations. Under Medicare regulations, a Chiropractor is a physician for purposes of correction of a subluxation only. Since Medicare would NOT pay the Chiropractor for physical therapy services as a physician, why would they pay him as a physical therapist?

Chiropractors DO NOT meet the Medicare qualifications as therapists and a practice who uses the DC's talents to provide therapy services "incident to" a medical doctor or a licensed physical therapist will "earn their stripes" as soon as the eventual audit hits their practice.

IF you have a PT or an OT that DOES NOT have a Medicare Provider number, we strongly suggest you file form 855-I immediately and obtain one. Under the regulations, the physician can not supervise the PTA AND, if the PT does not have a provider number, the MD must be in the office suite and in direct supervision of the "licensed therapist" in order for any of the services to be billable.

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