

Medicare B Guideline Index

Medical Necessity

Section 1862(a)(1)(A) of the SSA states: "No Medicare payment shall be made for expenses incurred for items or services which... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Services which do not meet the requirements for covered therapy services in Medicare manuals are not payable as therapy services. Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation, do not constitute covered therapy service for Medicare purposes.

To be considered reasonable and necessary, the services must meet Medicare guidelines. The guidelines for coverage of outpatient therapies have basic requirements in common.

- The patient has a condition that requires therapy services.
- There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time. If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, therapy is not covered.
- When there is limited potential for restoration of function due to a chronic progressive condition, such as multiple sclerosis or Parkinson's disease, establishment of a safe and effective maintenance program must require the unique skills of a therapist.
- A therapy plan of care is developed and certified by a physician/NPP in which all services provided are specific and effective treatments for the patient's condition according to accepted standards of medical practice, and, the amount, frequency, and duration of the services are reasonable.
- The services that are provided must meet the description of skilled therapy below.

Skilled Therapy

Services that do not require the professional skills of a physician, NPP or therapist to perform or supervise are not medically necessary. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self management program, restorative program or caregiver assisted program, payment cannot be made for therapy services. Consider the following points when determining if a service is skilled.

- Rehabilitative therapy occurs when the skills of a therapist (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service, whose goal is improvement of an impairment or functional limitation.
- The services shall be such a level of complexity and sophistication or the condition of the patient shall be such that services required can only be safely and effectively performed by a qualified therapist or therapy assistant. Services that do not require the performance or supervision of a therapist, or therapy assistant under the 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 therapist, physician or NPP.
- 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 threaten the illness or injury, or whether the service(s) can be carried out by non-skilled personnel.
- Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Patients must require the unique skills of a therapist to realize improved function in order for therapy to be covered. For example, therapy may not be covered for a patient who developed temporary weakness from a brief period of bed rest following abdominal surgery. It is reasonably expected that as discomfort reduces and the patient gradually resumes daily activities, function will return without the intervention of a therapist.
- If at any point in the treatment of an illness or injury it is determined that the treatment is not rehabilitative, or becomes repetitive and does not require the unique skills of a therapist, the services are non-covered.
- There may be circumstances where the patient, with or without the assistance of an aide or other caregiver, does activities planned by a therapist. Although these activities may be supportive to the patient's treatment, if they can be done by the patient, aides or other caregivers without the active participation of a therapist or therapy assistant they are considered unskilled.
- If function is not likely to improve because of a patient's limited ability to comprehend instructions, follow directions, or remember skills required to achieve an increase in function, rehabilitative therapy is not covered. However, limited services may be covered with supportive documentation, if the skills of a therapist are required to establish and teach a caregiver a safety or maintenance program.

- The use of therapy equipment, such as therapeutic pools or gym machines, does not necessarily make the treatment skilled.
- Medicare does not cover packaged or predetermined therapy services or programs. Services must be individualized, medically necessary and require the unique skills of a therapist.
- Services which do not meet requirements for covered therapy services under Medicare are not payable using codes and descriptions for therapy services. Also, services not provided under a therapy plan of care, or provided by staff who, are not qualified or appropriately supervised are not covered, payable therapy services.

Maintenance Therapy

Maintenance programs fall into either of the following categories.

Active rehabilitation treatment plan

A maintenance program may be an individualized plan of exercise and activity for patients and their caregiver(s) that therapist develop to maintain and enhance a patient's progress during the course of skilled therapy, as well as after discharge from therapy services. Maintenance programs are an integral part of therapy from the start of care and should be updated and modified as the patient progresses. As the patient or caregiver masters an activity or exercise, transition to a maintenance program for completion of the activity or exercise is expected. Prior to discharge, the therapist may revise the maintenance program based on the patient's attained functional status. Maintenance programs are not covered if established after the rehabilitative therapy has been completed.

Evaluation and maintenance therapy without rehabilitation therapy

When there is no expectation of significant functional improvement, therapy may be covered for the establishment of a safe and effective maintenance program to maintain or to prevent decline in function. Maintenance programs are covered if the specialized knowledge and judgment of a therapist is required to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel, and make infrequent but periodic reevaluations of the plan. For example, the skills of a physical therapist (PT) may be covered to develop a maintenance program for a patient with multiple sclerosis for services intended to prevent or minimize deterioration in gait ability caused by the medical condition, when the patient's current condition does not get justify the need for rehabilitative physical therapy treatment. Evaluation, development of the program and training the family/caregivers would require the skills of a therapist. The skills of a therapist are not required to carry out the maintenance program.

Instruction in a maintenance program required to delay or minimize functional deterioration in patients suffering from a chronic disease requires supporting documentation when more than 2-4 visits are provided.

Non-covered indications for maintenance programs include the following services.

- Non-individualized services
- Services considered to be routine or non-skilled (e.g., supportive nursing services, endurance training)
- Maintenance programs for patients without a complex condition that requires development of such a program by a skilled therapist
- Exercises or activities that could have been transitioned to an independent or caregiver assisted program.
- Noncompliance by patient or caregiver(s)
- Continuation of treatment solely for the purpose of staff training and education, or development of a formal maintenance program after rehabilitative therapy has been completed

General Documentation Requirements

Initial Evaluation

The initial evaluation establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals and measuring progress. Initial evaluations need to provide objective, measurable documentation of the patient's impairments and how any noted deficits affect ADLs/IADLs and result in functional limitations. Functional limitations refer to the inability to perform actions, tasks and activities that constitute the "usual activities" for the patient. Functional limitations must be meaningful to the patient and caregiver, and must have potential for improvement. In addition, the remediation of such limitations must be recognized as medically necessary.

The evaluation should include the following items.

1. Reason for referral ... "What brings the patient to therapy at this time?"
 - Patients must exhibit a significant change from their "usual" physical or functional ability to warrant an evaluation.
 - Provide an objective description of the changes in function that now necessitate skilled therapy. Simply stating "decline in function" does not adequately justify the initiation of therapy services.
2. Diagnosis and description of specific problem(s) to be evaluated
 - Include area of the body, and conditions and complexities that could impact treatment.
3. Subjective complaints and date of onset
4. Relevant medical history
 - Applicable medical history, medications, comorbidities (factors that make therapy more complicated or require extra precautions)
5. Prior diagnostic imaging/testing results
6. Prior therapy history for the same diagnosis, illness or injury
 - If recent therapy was provided, documentation must clearly establish that additional therapy is reasonable and necessary.
7. Social support/environment
 - Does the patient live alone, with a caregiver, in a group home, in a residential care facility, in a skilled nursing facility (SNF), ect?
 - i. What level of support is available, and what level of independence is required for the patient to be safe in the home environment?
 - Does the home situation have obstacles that the patient must overcome (e.g, stairs without handrails)?
 - What are the patient's usual responsibilities in the home environment?
8. Prior level of function
 - Key piece of information used for establishing potential, prognosis and realistic functional goals
 - Functional status just prior to the onset of the treating condition requiring therapy
 - Record in objective, measurable and functional terms

9. Functional testing
 - Objectively measure and/or describe the patient's current level of functioning.
Examples, based on the patient's need, may include:
 - Mobility status (transfers, bed mobility, gait, etc);
 - Self-care dependence (toileting, dressing, grooming, etc); meaningful ADLs/IADLs;
 - Pain, and how it limits function; and
 - Functional balance
10. Objective impairment testing
 - Testing done to determine the source of cause of the functional limitation(s), such as ROM, manual muscle testing, coordination, tone assessment, etc.
 - Use concise, objective measurements. Avoid minimal/moderate/severe types of descriptions when more specific definitions or measurements are available. For example, when measuring shoulder flexion AROM, document degrees of motion, rather than documenting, "Shoulder flexion: minimal loss of motion."
11. Assessment
 - Summary of the therapist's analysis of the condition being evaluated based on the examination of the patient. Clinical reasoning for treatment should be evident when further therapy is recommended.
12. Prognosis for return to prior functional status, or the maximum expected condition
13. Plan of care (see paragraph below)
14. Signature and credentials of the therapist or physician/NPP completing the initial evaluation and plan of care.

Each therapy discipline must have a separate plan of care. The plan of care (POC) must contain ALL of the following information.

Required POC Element	Additional Points
Diagnosis	The diagnosis should be specific and as relevant to the problem being treated as possible. In many cases, both a medical diagnosis (obtained from the physician/NPP) and an impairment-based treatment diagnosis are relevant.
Long Term Goals (LTGs)	<p>LTGs should reflect the final level the patient is expected to achieve as a result of therapy. The LTGs should be realistic, and should have a positive effect on the quality of the patient's everyday functions.</p> <p>LTGs should be <u>function-based</u> and written in objective, measurable terms with a predicted date for achieving the goals. Goals should relate to the findings documented in the evaluation.</p>
Type of Treatment	The type of treatment includes the type of therapy discipline operating under this POC (PT or OT) and should describe the types of treatment modalities, procedures or interventions to be provided.
Amount of Treatment	<p>Refers to the number of times in a day the type of treatment will be provided. Where not specified, one treatment session a day is assumed.</p> <p>Treatment provided more than one session per day per discipline will require additional documentation to support this amount of therapy.</p>
Duration of Treatment	Refers to the number of weeks, or the number of treatment sessions, for this plan of care.
Frequency of Treatment	<p>Refers to the numbers of times in a week that the type of treatment is provided.</p> <p>Treatment more than two or three times a week is expected to be a rare occurrence.</p> <p>Treatment frequency of greater than three times per week requires documentation to support this intensity.</p>

Weekly Notes

Weekly notes provide justification for the medical necessity of treatment. Weekly notes must be written by a therapist or physician/NPP, at least once every seven days. Writing weekly notes more frequently than the minimum is encouraged to support the medical necessity of treatment. A weekly note is not a separately billable service.

The required weekly note elements include:

- Date of beginning and end of the reporting period that this report refers to;
- Date that the report was written by the therapist;
- Objective reports of the patient's subjective statements;
- Objective measurements (impairment/function testing) to quantify progress and support justification for continued treatment;
- Description of changes in status relative to each goal currently being addressed. Descriptions shall make identifiable reference to goals in the current plan of care;
- Assessment of improvement, extent of progress (or lack thereof) toward each goal;
- Plans for continuing treatment, including documentation of treatment plan revisions as appropriate;
- Changes to long or short term goals;
- Signature with credentials of the therapist or physician/NPP who wrote the report
- Statement of need for continued skilled service.

Treatment Notes

Medical record documentation is required for every treatment day, and every therapy service to justify the use of codes and units on the claim.

The treatment note must include the following required information:

- Date of treatment;
- Identification of each specific treatment, intervention or activity provided in language that can be compared with the CPT codes to verify correct coding;
- Record of the time spent in services represented by timed codes under Timed Code Treatment minutes;
- Record of the Total Treatment Time in minutes, which is the sum of the timed and untimed services;
- Signature and credentials of each individual that provided skilled interventions.

In addition, the treatment note may include any information that is relevant in supporting the medical necessity and skilled nature of the treatment such as:

- Patient comments regarding pain, function, compliance with self management techniques/home exercise program (HEP), etc;
- Significant improvement or adverse reaction to treatment;
- Significant, unusual or unexpected changes in clinical status;
- Parameters of modalities provide and/or specifics regarding exercises such as sets, repetitions, weight;
- Description of skilled components of the specific exercises, training or actives;

- Instructions given for HEP, restorative of self/caregiver managed program, including updates and revisions;
- Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist);
- Communication with patient, family or caregiver;
- Equipment provided
- Any additional relevant information to support that the patient continues to require skilled therapy and that the unique skills of a therapist were provided.

If grid or checklist forms are used for daily notes or exercise/activity logs, include the signature and credentials of the therapist or assistant providing the service each day. Listing of exercise names (e.g. pulleys, UBE, TKE, SLR) does not alone imply that skilled treatments have been performed over multiple sessions. Be sure to occasionally document the skilled components of the exercises so they do not appear repetitive and therefore, unskilled. Documenting functional activities performed (e.g., "ambulated 35 feet with min assist", "upper body dressing with set up and supervision") also does not alone imply that skilled treatment was provided. The skilled components/techniques of the therapist used to improve the functional activity should be documented to support medical necessity.

Do not record treatment time as "Time in/Time out" for the entire session as this does not accurately reflect the actual treatment time. Do not "round" all treatments to 15-minute increments, but rather record the actual treatment time.

Only "intra-service care" of skilled therapy services should be reflected in the time documentation. Do not include unbillable time, such as time for:

- Changing;
- Waiting for treatment to begin
- Waiting for equipment
- Resting
- Toileting
- Performing unskilled or independent exercises or activities

Utilization Guidelines and Maximum Billable Units per Date of Service

Rarely, except during an evaluation, should therapy session length be greater than 30-60 minutes. If longer sessions are required, documentation must support as medically necessary the duration of the session and the amount of activities/procedures performed.

The following timed modalities and procedures should be reported no more than 4 (four) units per code per day per discipline; additional units require supportive documentation.

97032, 97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, 97760, 97761, 97762.

CPT 97001 – Physical therapy evaluation
CPT 97003 – Occupational therapy evaluation

The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient self-reporting. Evaluations must be completed by therapists or physician/NPPs and are required prior to beginning therapy for determining the medical necessity of initiating rehabilitative or maintenance services. Patients must exhibit a significant change from normal functional ability to warrant an evaluation. The evaluation should clearly describe the reason for referral.

Factors that influence the complexity of the evaluation process include the clinical findings, extent of loss of function, social considerations, and the patient's overall function and health status.

The evaluation process assesses the severity of the current problem, the possibility of multi-site or multi-system involvement, the presence of pre-existing systemic conditions or diseases, and the stability of the condition.

If the patient presents with multi-system involvement and/or multiple site involvement, all areas/conditions should be assessed at the initial evaluation (i.e., cervical plain and knee pain; low back pain and rotator cuff; cervical pain and low back pain.) Only one evaluation code should be used, and all areas assessed.

Therapists also consider the level of the current impairments and the probability of prolonged impairment, functional limitation and disability, the living environment, and the social supports (i.e., the potential for effecting an improvement in the patient's functional ability).

Initial evaluations may be covered when the documentation justifies the need for a skilled therapy evaluation, even if it is determined that the patient does not require a skilled level of treatment.

Consider the following point when billing for an evaluation.

- If treatment is given on the same day as the initial evaluation, the treatment is billed using the appropriate CPT codes. The documentation must clearly describe the treatment that was provided in addition to the evaluation.

Additional Documentation Requirements for 97001 and 97003

Refer to the Documentation Requirements Section if this LCD for further information.

CPT 97002 – Physical therapy reevaluation
CPT 97004 – Occupational therapy reevaluation

The reevaluation is focused on evaluation of progress towards current goals and making a professional judgment about continued care, modifying goals and/or treatment, or terminating services. Reevaluation provides additional objective information not included in other documentation, such as treatment or progress notes.

Consider the following points when billing for a reevaluation.

- Documentation must show a significant improvement, decline or change in patient's diagnosis, condition or functional status that was not anticipated in the current plan of care. When a patient exhibits a demonstrable change in functional ability, a reevaluation may be necessary to revise long term goals and interventions.
- If a patient is hospitalized during the therapy interval, a reevaluation may be medically necessary if there has been a significant change in the patient's condition which has caused a change in function, long term goals, and/or treatment plan.
- Therapy reevaluations should contain all the applicable components of an initial evaluation and must be completed by a therapist or physician/NPP.
- A reevaluation is not a routine, recurring service. Do not bill for routine reevaluations, including those done for the purpose of completing an updated plan of care, recertification report, a weekly note, physician progress report or discharge summary. Although some state regulations and practice acts require reevaluations at specific intervals, for Medicare payment, reevaluations must meet Medicare coverage guidelines.

THERAPEUTIC PROCEEDURES

General Guidelines for Therapeutic Procedures

(CPT codes 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97750, 97755, 97760, 97761 and 97762)

Therapeutic procedures are procedures that attempt to reduce impairments and restore function through the applications of clinical skills and/or services.

CPT codes 97110, 97112, 97113, 97116, 97124, 97139 and 97140 are designed for one or more areas.

Use of these procedures requires the physical therapist to have direct (one-on-one) patient contact. Only the actual time of the provider's direct contact with the patient providing a service which requires the skills and expertise of that provider is considered for coverage. Supervision of a previously taught exercise or exercise program, patients performing an exercise independently without direct contact by the provider, or use of different exercise equipment without requiring the intervention/skills of the therapist are not covered. The patient may be in the facility longer than that period of time, but only the time the provider is actually providing direct, one-on-one, patient contact which requires the skills of a therapist is considered covered time for these procedures, and only those minutes of treatment should be recorded.

Use of these procedures is expected to result in improvement of the limitations/deficits in a reasonable and generally predictable amount of time.

Under Medicare, time spent in documentation of services (medical record production) is part of the coverage of the respective CPT code.

CPT codes 97110, 97112, 97113, 97116, and 97530 describe several different types of therapeutic interventions. The expected goals documented in the treatment plan, effected by the use of each of these procedures, will help define whether these procedures are reasonable and necessary. Therefore, because any one or a combination of these procedures may be used in a treatment plan, documentation must support the use of each procedure as it relates to a specific therapeutic goal. On each treatment visit the treatment record must support the codes billed and must specify which exercise/activity is being performed for each code billed. Documentation must also justify the coverage of multiple services/units of each code. In general, no more than 1-2 services/units of time for each code are needed on a date of service. Similarly, no more than 2-3 of these different codes are generally covered on a visit date. Documentation must support each code and the number of services/units of time. For example, 10 units of time for 5 different codes would be unlikely.

CPT 97110 – Therapeutic Exercises to develop strength and endurance, range of motion and flexibility (one or more areas, each 15 minutes)

Therapeutic exercises are used for the purpose of restoring strength, range of motion and flexibility. Therapeutic exercises may be described as active, active-assisted, or passive participation (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching and strengthening).

Exercises to promote overall fitness, flexibility, improved endurance, aerobic conditioning, weight reduction, and maintenance exercise to maintain range of motion and/or strength are non-covered. In addition, exercises that do not require, or no longer require, the skilled assessment and intervention of a therapist are non-covered. Repetitive type exercises often can be taught to the patient or a caregiver as part of a self-management, caregiver or nursing program.

Many therapeutic exercises may require the unique skills of a therapist to evaluate the patient's abilities design the program and instruct the patient or caregiver in the safe completion of the special technique. However, after the teaching is completed, repetition of the exercise, and monitoring for the completion of the task, is non-covered care. One rep max ther ex requires the skills of a therapist but must result in an increased independent functional mobility.

Therapeutic exercises may be reasonable and necessary for a loss or restriction of joint motion, strength, functional capacity or mobility, which has resulted from a specific disease or injury.

Documentation for therapeutic exercises must show objective loss of joint motion, strength, mobility (i.e., degrees of motion, strength grades, and levels of assistance).

Documentation should include not only measurable indicators such as functional loss of joint motion or muscle strength, but also information on the impact of these limitations on the patient's life and how improvement in one or more of these measures leads to improved function.

Documentation of progress must show the condition is responsive to the therapy chosen and that the response is (or is expected to be) clinically meaningful. Metrics of progress that are functionally meaningful (or obviously related to clinical functional improvement) should be used whenever possible. For example, long courses of therapy resulting in small changes in range of motion might not represent meaningful clinical progress benefiting the patient's function.

Documentation should describe new exercises added, or changes made to the exercise program to help justify that the services are skilled.

Documentation must also show that exercises are being transitioned as clinically indicated to an independent or caregiver-assisted exercise program ("home exercise program"(HEP)). An HEP is an integral part of the therapy plan of care and should be modified as the patient progresses during the course of treatment. It is appropriate to transition portions of the treatment to an HEP as the patient or caregiver master the techniques involved in the performance of exercise.

If an exercise is taught to a patient and performed for the purpose of restoring functional strength, range of motion, and flexibility, CPT code 97110 is the appropriate code. For example, a gym ball exercise used for the purpose of increasing the patient's strength should be considered as therapeutic exercise when coding for billing. Also, taping, such as McConnell taping, to facilitate a strengthening intervention would be billed as 97110.

Passive exercises not related to restoring specific loss of function are non-covered.

Documentation must clearly support the need for continued therapeutic exercise greater than 12-18 visits within a 4-6 week period.

For many patients a passive-only exercise program should not be used more than 2-4 visits to develop and train the patient or caregiver in performing PROM. Documentation would be necessary to support services beyond this level (such as PROM where there is an unhealed, unstable fracture, or new rotator cuff repair, requiring the skills of a therapist to ensure that the extremity is maintained in proper position and alignment during the PROM).

Additional Documentation Requirements for 97110

- Objective measurements of loss of strength and range of motion (with comparison to the uninvolved side) and effect on function
- Specific exercises performed purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills and expertise of the therapist were required.

CPT 97112 – Neuromuscular Re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (one more areas, each 15 minutes)

This therapeutic procedure is proved for the purpose of restoring balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation (PNF), Feldenkreis, Bobath, BAP's boards, vestibular rehabilitation and desensitization techniques).

This procedure may be reasonable and necessary for impairments which affect the body's neuromuscular system such as:

- Loss of deep tendon reflexes and vibration sense accompanied by paresthesia, burning, or diffuse pain of the feet, lower legs, and/or fingers;
- Nerve palsy, such as peroneal nerve injury causing foot drop;
- Muscular weakness or flaccidity as a result of a cerebral dysfunction, a nerve injury or disease or having had a spinal cord disease or trauma;
- Poor static or dynamic sitting/standing balance;
- Loss of gross and fine motor coordination
- Hypo/hyper tonicity

Documentation for neuromuscular re-education must show impairments which affect the neuromuscular system as listed above. Documentation must contain objective measurements/ratings of loss of motion, strength, balance, coordination, and/or mobility, e.g., degrees of motion, strength grades, assist for balance and mobility, specific tests for balance and coordination.

If an exercise is taught to the patient and performed for the purpose of restoring functional balance, motor coordination, kinesthetic sense, posture, or proprioception for sitting or standing activities, CPT 97112 is the appropriate code. For example, a gym ball exercise used for the purpose of improving balance should be considered as neuromuscular reeducation when coding for billing. Taping, such as McConnell taping or kinesiio taping techniques, to enhance proprioception may be billed as 97112.

When therapy is instituted for falls, documentation should clearly indicate:

- Specific fall dates and/or hospitalization(s) and reason for the fall(s), if known;
- Most recent prior functional level of mobility, including assistive device, level of assist, frequency of falls or, "near-falls";
- Cognitive status;
- Prior therapy intervention;
- Functional loss due to the recent change in condition;
- Balance assessments (preferably standardized), lower extremity ROM and muscle strength testing;
- Carry-over of therapy techniques to objectively document progress.

It may not be reasonable and necessary to extend visits for a patient with falls, or any patient receiving therapy services, if the purpose of the extended visits is to:

- Remind the patient to ask for assistance;
- Offer close supervision of activities due to poor safety awareness;
- Remind a patient to slow down;

- Offer routine verbal cues for compensatory or adaptive techniques already taught;
- Remind a patient to use an assistive device;
- Train multiple caregivers; or
- Begin a maintenance program

In these instances, the care should be turned over to supportive personnel or caregivers since repetitive cues and reminders do not require the skills of a therapist.

Documentation must clearly support the need for continued neuromuscular reeducation greater than 12-18 visits within a 4-6 week period.

Additional Documentation Requirements for 97112

- Objective measurements of strength and range of motion (with comparison to the uninvolved side) and mobility, balance and coordination deficits and effect on function
- Specific exercises performed, purpose of exercises as related to function, instructions given, and/or assistance needed to support that the skills and expertise of a therapist were required.

CPT 97542 – Wheelchair Management/Assessment, Fitting, and Training

This procedure describes the skilled intervention therapists provided related to wheelchair activities for patients who are wheelchair bound. According to CPT Changes 2006 – An Insider’s View, a wheelchair assessment may include but is not limited to the patient’s strength, endurance, living situation, and ability to transfer in and out of the chair, level of independence, weight, skin integrity, muscle tone, and sitting balance. Following verification of the patient’s need, measurements are taken prior to ordering the equipment. This measurement occasionally involves testing the patient’s abilities with various chair functions including propulsion, transferring from the chair to other situations (bed, toilet, car), and use of the chair’s locking mechanism on various types of equipment for optimal determination of the appropriate equipment by the patient and caregiver.

Consider the following points when providing wheelchair management services.

- Assessment for non-specialized wheelchairs, cushions, lapboards, wheelchair trays, or lap buddies for a patient without a complicating condition typically does not require the unique skills of a therapist.
- A seating assessment is not reasonable and necessary (R&N) for every patient.
- Skilled intervention would not be necessary for wheelchair issues that the patient can self-correct.
- The patient/caregiver must have the capacity and willingness to learn from instructions.
- When wheelchair and seating assessments are reasonable, care should be turned over to supportive personnel or a caregiver once the necessary modifications are completed.
- Ongoing visits for increasing sitting times are generally not reasonable and necessary when no patient problems are documented.
- Visits made for restraint reduction are generally non-covered.
- It is expected that multiple wheelchair and seating deficits discovered during the initial evaluation would be treated concurrently. If not, documentation must indicate that a new problem/deficit occurred, or include rationale why a problem being treated in the later stages of therapy was not addressed previously.

Typically up to 3 dates of service should be sufficient. Coverage beyond this utilization must have documentation to support the need for the unusual frequency or duration of treatment sessions.

Additional Documentation Requirements for 97542

- Documentation for a skilled wheelchair assessment should include the following:
 - What recent event prompted the need for a skilled wheelchair assessment;
 - What previous wheelchair assessments have been completed, such as during a Part A SNF stay;
 - Most recent prior functional level;
 - What intervention was tried by nursing staff, caregivers or the patient themselves;
 - Functional deficit due to poor seating or positioning;
 - Objective assessments of applicable impairments such as range of motion (ROM), strength, sitting balance, skin integrity, sensation and tone.
- When billing CPT code 97542 for wheelchair management/training, documentation must relate the training to expected functional goals that are attainable by the patient and/or caregiver.
- The response of the patient to the instruction or fitting
- Documentation must clearly support that the services rendered required the skills and expertise of the therapists.