Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital

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Instructions for Use

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Related Medicare Advantage Medical Policy

- Hospital, Emergency, and Ambulance Service

Coverage Rationale

Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services)

Conditions of Coverage

Outpatient Therapy Services are covered in accordance with certain conditions as outlined in the Services Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Outpatient Rehabilitation Therapy.

For members in States that participate in the Outpatient Therapy Utilization Management Program:

- UnitedHealthcare uses the criteria below to supplement the general Medicare criteria regarding rehabilitation services at Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services in order to ensure consistency in reviewing the conditions to be met for coverage of rehabilitation services, as well as reviewing when such services may be medically necessary. Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's medical factors support rehabilitation services.
- Additional Criteria may exist through the Optum Physical Health Outpatient Rehabilitation Therapy program. Reference materials are available at Clinical Policies - Provider Portal (myoptumhealthphysicalhealth.com).

Reasonable and Necessary

To be covered, services must be skilled Therapy Services 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. A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

Skilled Therapy Services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

Services that do not meet the requirements for covered Therapy Services in Medicare manuals are not payable using codes and descriptions as Therapy Services. For example, services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute Therapy Services for Medicare purposes. Also, services not provided under a therapy plan of care, or provided by staff who are not qualified or appropriately supervised, are not payable Therapy Services.

To be considered reasonable and necessary, each of the following conditions must be met.

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition.

  Notes:
  - Acceptable practices for Therapy Services are found in:
    - Medicare manuals (such as Publications 100-2, 100-03 and 100-04);
    - Local Coverage Determinations; and
    - Guidelines and literature of the professions of Physical Therapy, Occupational Therapy, and speech-language pathology.
  - When establishing the plan of care, the services must relate directly and specifically to a written treatment plan as described in §220.1.2 of Medicare Benefit Policy Manual, Chapter 15). The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated). Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.1.2 – Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services.
- The services shall be of such a level of complexity and sophistication or the condition of the member shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of Physical Therapy and Occupational Therapy by or under the supervision of a 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. Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care.
- If the Health Plan 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, the Health Plan shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing a claim, the Health Plan finds that services were not furnished under proper supervision, the claim shall be denied.
- While a member's particular medical condition is a valid factor in deciding if skilled Therapy Services are needed, a member's diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel.
- 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.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services.

Documentation Requirements for Therapy Services

To be payable, the medical record and the information on the claim form must consistently and accurately report covered Therapy Services, as documented in the medical record. Documentation must be legible, relevant, and sufficient to justify the services billed. In general, services must be covered Therapy Services provided according to Medicare requirements. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all requirements applicable to Medicare claims.

For more detailed documentation requirements, refer to the Medicare Benefit Policy Manual, Chapter 15, §220.3 – Documentation Requirements for Therapy Services.

Covered Settings for Outpatient Rehabilitation Services

Comprehensive Outpatient Rehabilitation Facility (CORF)

CORF is defined as a facility that is primarily engaged in providing outpatient rehabilitation to the injured and disabled or to patients recovering from illness.

For more detailed guidelines, refer to the Medicare Benefit Policy Manual, Chapter 12 – Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage.

Physician's Office or Therapist's Office

Refer to the:

- Medicare Benefit Policy Manual, Chapter 15, §220 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance.
- Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology.

Member's Place of Residence

A member's residence is wherever the member makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, home for the aged, or some other type of institution. Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.1.2 – Patient's Place of Residence.

Inpatient Rehabilitation Services

Inpatient Rehabilitation Facility (IRF)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening the post-admission physician evaluation, the overall plan of care and the admission orders) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (Physical Therapy, Occupational Therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or Occupational Therapy.
- The patient must generally require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.
- The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time.
- The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
- The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

For detailed guidelines, refer to the Medicare Benefit Policy Manual, Chapter 1, §110 – Inpatient Rehabilitation Facility (IRF) Services.

For the list of medical conditions and facility requirements for intensive rehabilitative services, refer to the CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements.

Skilled Nursing Facility

Inpatient skilled nursing facility care (up to 100 days per benefit period) including room and board, skilled nursing care and other customarily provided services in a Medicare certified skilled nursing facility bed are covered when coverage factors are met.

For more detailed guidelines and examples, refer to the Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care – General.

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Skilled Nursing Facility.

Long Term Acute Care Hospital (LTACH)

LTACHs are certified under Medicare as short-term acute care hospitals that have been excluded from the acute care hospital inpatient prospective payment system (PPS) under §1886(d)(1)(B)(iv) of the Act and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days.

Medicare does not have a National Coverage Determination (NCD) or Local Coverage Determinations (LCDs) for determining medical necessity for long term acute care hospitalization.

UnitedHealthcare may utilize InterQual®, an evidence-based clinical decision tool, as a screening tool as part of their medical review of LTACH. CMS does not require the use of a specific criteria set. In all cases, in addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record. Refer to Medicare Program Integrity Manual, Chapter 6, Section 6.5.1- Screening Instruments.

Refer to the InterQual® LOC: Long-Term Acute Care.

Click here to view the InterQual® criteria.

Also refer to the:

- Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A.
- Long Term Hospital Care Coverage (medicare.gov).
- Medicare Claims Processing Manual, Chapter 3 - Inpatient Hospital Billing §150 - Long Term Care Hospitals (LTCHs) PPS.
- Medicare Program Integrity Manual, Chapter 6, Section 6.5 – Medical Review of Inpatient Hospital Claims for Part A Payment.
- Centers for Medicare and Medicaid Services, Medicare Learning Network, Long-Term Care Hospital Prospective Payment System (MLN6922507).

Rehabilitation Services for Members with Vision Impairment

Rehabilitation services are covered for members with a primary vision impairment diagnosis pursuant to a written treatment plan by the member's physician and provided by a qualified occupational or physical therapist (or a person supervised by a qualified therapist) or incident to physician services.

- Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).
- The member must have the potential for restoration or improvement of lost functions in a reasonable amount of time.
- Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning are not covered.
- A person with profound impairment in both eyes (i.e., best corrected visual acuity is less than 20/400 or visual field is 10 degrees or less) would generally be eligible for, and may be provided, rehabilitation services under HCPCS code 97535, (self-care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).

Refer to the Medicare Program Memorandum AB-02-078, Provider Education Article: Medicare Coverage of Rehabilitation Services for Beneficiaries With Vision Impairment, Change Request 2083, May 29, 2002.

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable .For specific LCDs/LCAs, refer to the table for Rehabilitation Services for Members with Vision Impairment.

Other Rehabilitation Therapy Services

Other examples of rehabilitation Therapy Services include, but are not limited to:

- Aqua/pool therapy/hydrotherapy only as part of an authorized Physical Therapy treatment plan conducted by a licensed physical therapist with the therapist in attendance.
  - For descriptions of aquatic therapy in a community center pool; refer to the Medicare Benefit Policy Manual, Chapter 15, §220C – General.
  - Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. For specific LCDs/LCAs, refer to the table for Aqua/Pool/Hydrotherapy.
- Massage therapy, unless it is part of a multi-modality authorized treatment plan appropriate to the patient's diagnosis plan with a licensed therapist in attendance. Refer to the Medicare Benefit Policy Manual, Chapter 15, §230.5 – Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP).
- Vocational and prevocational assessment and training related solely to specific employment opportunities, work skills or work settings. Refer to the. Medicare Benefit Policy Manual, Chapter 15, §230.2 – Practice of Occupational Therapy, D-Application of Medicare Guidelines to Occupational Therapy Services.
- General exercises that promote overall fitness. Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General.
- Activities that provide a diversion or general motivation. Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General.
- Passive Rehabilitation Therapy for Mandibular Hypomobility. Medicare does not have a National Coverage Determination (NCD) for passive rehabilitation therapy for mandibular hypomobility. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Treatment of Temporomandibular Joint Disorders.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92526	Treatment of swallowing dysfunction and/or oral function for feeding
97012	Application of a modality to 1 or more areas; traction, mechanical
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes

CPT Code	Description
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem)
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

CPT Code	Description
97799	Unlisted physical medicine/rehabilitation service or procedure

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HCPCS Code	Description
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Definitions

Occupational Therapy: Services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. Medicare Benefit Policy Manual, Chapter 15, §230.2 – Practice of Occupational Therapy.

Physical Therapy: Services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. Medicare Benefit Policy Manual, Chapter 15, §230.1 – Practice of Physical Therapy.

Qualified Professional: A physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to furnish Therapy Services, and who also may appropriately furnish Therapy Services under Medicare policies. Qualified Professional may also include a physical therapist assistant (PTA) or an Occupational Therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (refer to section 230.1 and 230.2) and may not supervise other therapy caregivers.
Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology.

Speech-Language Pathology Services: The services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia) regardless of the presence of a communications disability.
Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology.

Therapy Services: Skilled services furnished according to the standards and conditions in CMS manuals, (e.g., Medicare Benefit Policy Manual, Chapter 15 and in Medicare Claims Processing Manual, Chapter 5), within their scope of practice by Qualified Professionals or qualified personnel, as defined in §230 of the Medicare Benefit Policy Manual, Chapter 15. Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology Medicare Benefit Policy Manual (cms.gov).

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD or LCA is found refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Outpatient Rehabilitation Therapy				
N/A	L34560 Home Health Occupational Therapy	A53057 Billing and Coding: Home Health Occupational Therapy	A and B and HHH MAC	Palmetto**
	L34427 Outpatient Occupational Therapy	A53064 Billing and Coding: Outpatient Occupational Therapy	Part A and B MAC	Palmetto**
	L34049 Outpatient Physical and Occupational Therapy Services	A57067 Billing and Coding: Outpatient Physical and Occupational Therapy Services	Part A and B MAC	CGS

NCD	LCD	LCA	Contractor Type	Contractor Name
Outpatient Rehabilitation Therapy				
N/A	L33631 Outpatient Physical and Occupational Therapy Services	A56566 Billing and Coding: Outpatient Physical and Occupational Therapy Services	Part A and B MAC	NGS
	N/A	A52773 Billing and Coding: Therapy Evaluation, Re-Evaluation and Formal Testing	Part A and B MAC	Noridian
	N/A	A53309 Billing and Coding: Therapy Evaluation, Re-Evaluation and Formal Testing	Part A and B MAC	Noridian
	L34428 Outpatient Physical Therapy	A53065 Billing and Coding: Outpatient Physical Therapy	Part A and B MAC	Palmetto**
	L34564 Home Health Physical Therapy	A53058 Billing and Coding: Home Health Physical Therapy	HHH MAC	Palmetto**
	L34563 Home Health Speech-Language Pathology	A53052 Billing and Coding: Home Health Speech-Language Pathology	HHH MAC	Palmetto**
	L33942 Physical Therapy - Home Health	A57311 Billing and Coding: Physical Therapy - Home Health	HHH MAC	CGS
	L35070 Speech - Language Pathology (SLP) Services: Communication Disorders	A54111 Billing and Coding: Speech Language Pathology (SLP) Services: Communication Disorders	Part A and B MAC	Novitas**
	L34046 Speech-Language Pathology	A57040 Billing and Coding: Speech-Language Pathology	Part A and B MAC	CGS
	L34429 Outpatient Speech Language Pathology	A56868 Billing and Coding: Outpatient Speech Language Pathology	Part A and B MAC	Palmetto**
	L33580 Speech-Language Pathology	A52866 Billing and Coding: Speech-Language Pathology	Part A and B MAC	NGS
	N/A	A55710 Lymphedema Decongestive Treatment	Part A and B MAC	Noridian
	N/A	A52959 Billing and Coding: Lymphedema Decongestive Treatment	Part A and B MAC	Noridian
	• L34428 Outpatient Physical Therapy • L34427 Outpatient Occupational Therapy • L34564 Home Health Physical Therapy • L34560 Home Health Occupational Therapy	A53053 Billing and Coding: CPT Code 97755 - Assistive Technology Assessment	Part A and B MAC	Palmetto**

NCD	LCD	LCA	Contractor Type	Contractor Name
Outpatient Rehabilitation Therapy				
N/A	N/A	A52754 Non-Payment for Prefabricated Splints	Part A and B MAC	Noridian
	N/A	A56112 Non-Payment for Prefabricated Splints	Part A and B MAC	Noridian
	L34646 Psychological and Neuropsychological Testing	A57481 Billing and Coding: Psychological and Neuropsychological Testing	Part A and B MAC	WPS*
Skilled Nursing Facility				
N/A	N/A	A55503 Billing and Coding: Skilled Therapy Services in the SNF PPS Setting	Part A and B MAC	Noridian
	N/A	A55505 Skilled Therapy Services in the SNF PPS Setting	Part A and B MAC	Noridian
	L34834 Blood Glucose Monitoring in a Skilled Nursing Facility (SNF)	A56591 Billing and Coding: Blood Glucose Monitoring in a Skilled Nursing Facility (SNF)	Part A and B MAC	Novitas**
Rehabilitation Services for Members with Vision Impairment				
N/A	L34564 Home Health Physical Therapy	A53058 Billing and Coding: Home Health Physical Therapy	HHH MAC	Palmetto**
	L34560 Home Health Occupational Therapy	A53057 Billing and Coding: Home Health Occupational Therapy	A and B and HHH MAC	Palmetto**
Aqua/Pool/Hydrotherapy				
N/A	L34427 Outpatient Occupational Therapy	A53064 Billing and Coding: Outpatient Occupational Therapy	Part A and B MAC	Palmetto**
	L34049 Outpatient Physical and Occupational Therapy Services	A57067 Billing and Coding: Outpatient Physical and Occupational Therapy Services	Part A and B MAC	CGS
	L33631 Outpatient Physical and Occupational Therapy Services	A56566 Billing and Coding: Outpatient Physical and Occupational Therapy Services	Part A and B MAC	Palmetto**
	L34428 Outpatient Physical Therapy	A53065 Billing and Coding: Outpatient Physical Therapy	Part A and B MAC	Palmetto**
	L33942 Physical Therapy - Home Health	A57311 Billing and Coding: Physical Therapy - Home Health	HHH MAC	CGS

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Policy History/Revision Information

Date	Summary of Changes
10/01/2024	**Centers for Medicare & Medicaid (CMS) Related Documents** • Added notation for the state of Virginia to indicate "Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction"
09/01/2024	**Related Policies** • Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Hospital, Emergency, and Ambulance Services* **Coverage Rationale** ***Inpatient Rehabilitation Services*** Long Term Acute Care Hospital (LTACH) • Added language to indicate: ○ Long term acute care hospitals (LTACHs) are certified under Medicare as short-term acute care hospitals that have been excluded from the acute care hospital inpatient prospective payment system (PPS) under *§1886(d)(1)(B)(iv) of the Act* and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days ○ In addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record ○ Refer to *Medicare Program Integrity Manual, Chapter 6, Section 6.5.1- Screening Instruments* • Replaced language indicating "UnitedHealthcare may utilize InterQual®, an evidence-based clinical decision tool, *to make medical necessity determinations, if there is no NCD, applicable Local Coverage Determination (LCD)/Local Coverage Article (LCA), or Medicare manual guidance on coverage, or where the existing guidance provides insufficient clinical detail*" with "UnitedHealthcare may utilize InterQual®, an evidence-based clinical decision tool, *as a screening tool as part of their medical review of LTACH; Centers for Medicare & Medicaid Services (CMS) does not require the use of a specific criteria set*" **Supporting Information** • Archived previous policy version MMP079.11

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.