Medicare Part B Rules for Skilled Nursing Facilities
Explanation of Medicare Manual Chapter 15

Skilled Nursing Facility residents that participate in therapy services under Medicare Part B follow the rules in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."

The rules and regulations for each part of Medicare may differ (i.e.: Part A vs Part B), therefore, the rules should be obtained from the appropriate Chapter.

This Chapter (15) had a major update in January 2014 with the addition of verbiage for Skilled Maintenance Therapy services and additional requirements. Here is a link to Chapter 15 of the Manual.

The Manual details with requirements for skilled coverage, documentation and practice. All therapists treating Medicare Part B residents should familiarize themselves with the information listed.

Key Points From This Chapter:

220.0 – Coverage of Outpatient Rehab Therapy Services

A. Definitions: This section outlines Medicare Part B's definition of terminology currently used in the Manual.

Clinician: Is defined as "a physician, non-physician practitioner or a therapist (but ***not an assistant***, aide or any other personnel)" Medicare was very specific to add "but not an assistant" and uses the term "clinician" frequently

This is important to note as in later parts of the manual the word clinician is utilized when referring to documentation and treatment - and if one is not aware of Medicare's definition here, later parts of the Manual can be misinterpreted

Qualified Professional: Is defined as a PT, OT, SLP, physician, NP, clinical nurse specialist or PA who is licensed or certified by the state to furnish therapy services. Qualified professional may also include a PTA, OTA when furnishing services under the supervision of a qualified therapist who is working within the state scope of practice. Assistants are limited in the services they may furnish and may not supervise other therapy caregivers.

Therapy: In this Chapter is defined as only outpatient PT, OT and SLP services paid using the Medicare Physician Fee Schedule. (This includes Part B services to those residing in a SNF as an inpatient)

220.1.1-5 – Care of a Physician / Non-physician Practitioner

Orders: This paragraph states that there is "no Medicare requirement for an order," though goes on to state that "when documented in the medical record, an order provides evidence that the patient both needs therapy AND is under the care of the physician." Therefore, an order for therapy is not required for Medicare Part B coverage (though it may be required by a therapy State Practice Act and in that case would be needed). The Medicare Part B requirement for therapy is the certification of the therapy plan of care by the physician.

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Evaluations: Must be completed by a clinician to establish the plan of care prior to treatment.

Document the necessity for therapy through objective findings, lists conditions and complexities and describes the impact of the conditions and complexities on the prognosis or the plan of treatment such that it is clear to those that review the record

Must include a diagnosis and description of the problems to be treated

Plan of Care: Must be a written treatment plan established by the PT, OT or SLP who will provide the services

Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same CLINICIAN who establishes the plan.

Plan must include DX, LTG's, Type/Amount/Duration/Frequency of services

Progress Report:

Justification for the medical necessity of treatment

Minimum progress report period shall be at least once every 10 treatment days. The evaluation is visit 1 regardless of if treatment was provided.

Daily Treatment Encounter Note:

Purpose is to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim.

Required for every treatment day and every therapy service.

Shall include: Date, each specific intervention provided for and billed, identification of timed and untimed codes, signature and professional identification of qualified professional who furnished or supervised the services and a list of each person who contributed to the treatment

Re-certifications:

A recertification to the therapy plan of care is required no later than every 90 days. A recertification must contain all requirements of a plan of care.

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Discharge Summary:

Required for each episode of treatment. The discharge note shall be a progress report written by a CLINICIAN and shall cover the reporting period from the last progress report to the date of discharge.

These are only excerpts from Chapter 15 of the Medicare Benefit Policy Manual and should not be taken as an entirety. Practicing professionals should read this Chapter of the Manual prior to providing services to Part B beneficiaries.