## Coverage Summary

### Rehabilitation: Medical Rehabilitation (OT, PT and ST, Including Cognitive Rehabilitation)

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<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
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**Approved by:** UnitedHealthcare Medicare Benefit Interpretation Committee  
**Last Review Date:** 04/16/2019

### Related Medicare Advantage Policy Guidelines:

- Diathermy Treatment (NCD 150.5)
- Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (NCD 150.8)
- Melodic Intonation Therapy (NCD 170.2)
- Speech-Language Pathology Services for the Treatment of Dysphagia (NCD 170.3)
- Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (NCD 20.35)

**This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource 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. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.**

The benefit information in this Coverage Summary is based on existing national coverage policy, however Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

**Coverage Statement:** Medical rehabilitation (occupational therapy, physical therapy, speech-language pathology, including cognitive rehabilitation) is covered when Medicare coverage criteria are met.

**Guidelines/Notes:**

1. **Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy and Speech-Language Pathology Services)**
   a. **Conditions of Coverage**
      Outpatient therapy services are covered in accordance with certain conditions as outlined in the *Medicare Benefit Policy Manual, Chapter 15, §220.1 - Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services*. (Accessed March 27, 2019).

   b. **Reasonable and Necessary**
      1) **General**
      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. For further information, see Guideline 1.c (Rehabilitative Services) and Guideline 1.d (Maintenance Programs).

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.

2) To be considered reasonable and necessary, each of the following conditions must be met.
   a) 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). See the Medicare Benefit Policy Manual, Chapter 15, §220.1.2 - Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services. (Accessed March 27, 2019)
   b) 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. For additional guidance, see Guideline 1.d (Maintenance Programs).
   c) 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.

d) 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.

e) 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.

See the Medicare Benefit Policy Manual, Chapter 15, §220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services. (Accessed March 27, 2019)

c. **Rehabilitative Therapy**

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive objective measurements whenever possible (see objective measurement and other instruments for evaluation in the §220.3.C of the Medicare Benefit Policy Manual, Chapter 15). If an individual’s expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

For more detailed guideline, see the Medicare Benefit Policy Manual, Chapter 15, §220.2C - Rehabilitative Therapy. (Accessed March 27, 2019)

d. **Maintenance Program**

Maintenance program is a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

For more detailed guideline, see the Medicare Benefit Policy Manual, Chapter 15, §220.2D-Maintenance Programs. (Accessed March 27, 2019)


e. **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. (Accessed March 27, 2019)

f. Outpatient rehabilitation services maybe covered in the following settings:

1) 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 guideline, see the Medicare Benefit Policy Manual, Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage. (Accessed March 27, 2019)

2) Physician’s office or therapist’s office; see 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. Also see the Medicare Benefit Policy Manual, Chapter 15, §230 - Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology. (Accessed March 27, 2019)

3) 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. See the Medicare Benefit Policy Manual, Chapter 7, §30.1.2 - Patient’s Place of Residence. (Accessed March 26, 2019)

g. Therapy Caps

Although CMS implemented Therapy Caps effective January 1, 2006, this change does not affect the UnitedHealthcare MedicareComplete or UnitedHealthcare MedicareDirect plans.

For Medicare information regarding therapy caps, see the Medicare Claims Processing Manual, Chapter 5, §10.2 - The Financial Limitation Therapy Caps. (Accessed March 27, 2019)

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 27, 2019)

2. Inpatient Rehabilitation Services

a. 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.

1) 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.

2) 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.

3) 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.

4) The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

For detailed guideline, see the Medicare Benefit Policy Manual, Chapter 1, §110 - Inpatient Rehabilitation Facility (IRF) Services. (Accessed March 27, 2019)

For the list of medical conditions and facility requirements for intensive rehabilitative services, see the CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements. (Accessed March 27, 2019)

b. Skilled Nursing Facility; see the Coverage Summary for Skilled Nursing Facility (SNF) Care and Exhaustion of SNF Benefits

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed March 27, 2019)

3. Cognitive Therapy
In addition to the three required core CORF services, the CORF may furnish any of the other covered and medically necessary items and services listed in §20.2 of the Medicare Benefit Policy Manual, Chapter 12. These optional services must directly relate to, and be consistent with, the rehabilitation plan of treatment, and must be necessary to achieve the patient’s rehabilitation goals. When a CORF provides occupational therapy, speech-language pathology and/or respiratory therapy services in addition to the required physical therapy services, the physical therapy services shall represent the predominate rehabilitation service provided.

For occupational therapy, services include assessment of an individual’s level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities. See the Medicare Benefit Policy Manual, Chapter 12 §20.2 - Optional CORF Services. (Accessed March 27, 2019)

For discussion of payment rules; see the Medicare Benefit Policy Manual, Chapter 12 §30.1 Rules of Payment of CORF Services. (Accessed March 27, 2019)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) which address the development of cognitive skills exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx). (Accessed March 27, 2019)

4. **Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CPT code 93668)**

Supervised exercise therapy (SET) for members with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD) is covered when criteria are met. See the NCD for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35). (Accessed March 27, 2019)

5. **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).

See the Medicare Program Memorandum AB-02-078, Provider Education Article: Medicare Coverage of Rehabilitation Services for Beneficiaries With Vision Impairment, Change
Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&. (Accessed March 27, 2019)

6. Other examples of rehabilitation therapy services include, but are not limited to:

a. 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.
   

   Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&. (Accessed March 27, 2019)

   For descriptions of aquatic therapy in a community center pool; see the Medicare Benefit Policy Manual, Chapter 15, §220C - General. (Accessed April 10, 2019)

b. Fluidized therapy (fluidotherapy) as a part of an authorized physical therapy treatment plan for the treatment of acute or subacute, traumatic or nontraumatic, musculoskeletal disorders of the extremities. See the NCD for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (150.8) (Accessed March 27, 2019)

   Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&. (Accessed March 27, 2019)

c. Treatment of Dysphagia: Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability. See the NCD for Speech Language Pathology Services for the Treatment of Dysphagia (170.3). (Accessed March 27, 2019)

   Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&. (Accessed March 27, 2019)

   For electrical stimulation for the treatment of dysphagia, see the Coverage Summary for Stimulators: Electrical and Spinal Cord Stimulators.

d. Diathermy Treatment (CPT code 97024 and 97035)

   1) High energy pulsed wave diathermy machines have been found to produce some degree of therapeutic benefit for essentially the same conditions and to the same extent as standard diathermy. Accordingly, where the contractor’s medical staff has determined that the pulsed wave diathermy apparatus used is one which is considered therapeutically effective, the treatments are considered a covered service, but only for those conditions for which standard diathermy is medically indicated and only when rendered by a physician or incident to a physician’s professional services. See the NCD for Diathermy Treatment (150.5). (Accessed March 27, 2019)

   2) Heat treatment, including the use of diathermy and ultrasound for pulmonary conditions are not covered. There is no physiological rationale or valid scientific documentation of effectiveness of diathermy or ultrasound heat treatments for asthma,
bronchitis, or any other pulmonary condition and for such purpose this treatment cannot be considered reasonable and necessary. See the NCD for Heat Treatment, Including the Use of Diathermy and Ultra-Sound for Pulmonary Conditions (240.3). (Accessed March 27, 2019)

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&. (Accessed March 27, 2019)

e. 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. See 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). (Accessed March 27, 2019)

f. Vocational and prevocational assessment and training related solely to specific employment opportunities, work skills or work settings. See the Medicare Benefit Policy Manual, Chapter 15, §230.2 - Practice of Occupational Therapy, D-Application of Medicare Guidelines to Occupational Therapy Services. (Accessed March 27, 2019)

g. General exercises that promote overall fitness. See the Medicare Benefit Policy Manual, Chapter 15, §220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General. (Accessed March 27, 2019)

h. Activities that provide a diversion or general motivation. See the Medicare Benefit Policy Manual, Chapter 15, §220.2-Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General. (Accessed March 27, 2019)

i. Recreational therapy. See 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). (Accessed March 27, 2019)

j. Melodic Intonation Therapy
Melodic intonation therapy is covered service only for nonfluent aphasic patients unresponsive to conventional therapy, and the conditions for coverage of speech pathology services are met. See the NCD for Melodic Intonation Therapy (170.2) (Accessed March 27, 2019)

k. 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 at this time.
- For coverage guideline, refer to the UnitedHealthcare Commercial Medical Policy for Temporomandibular Joint Disorders. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy.)
- Committee approval date: April 16, 2019
II. 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.  (Accessed March 27, 2019)


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 (see 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. (Accessed March 27, 2019)

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. (Accessed March 27, 2019)

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. (Accessed March 27, 2019)

III. REFERENCES

See above

IV. REVISION HISTORY

04/16/2019 Annual review with the following updates:

Guideline 1.a (Outpatient Rehabilitation Therapy) - added the following:

Conditions of Coverage

Outpatient therapy services are covered in accordance with certain conditions as outlined in the Medicare Benefit Policy Manual, Chapter 15, §220.1 - Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services.
Guideline 1.c (Rehabilitative Therapy)

- Revised statement to see the Medicare manual to:

  For more detailed guideline, see the Medicare Benefit Policy Manual, Chapter 15, §220.2C - Rehabilitative Therapy.

- Deleted the following (also in the referenced Medicare Manual):

  Rehabilitative therapy services are skilled procedures that may include but are not limited to:
  - Evaluations and reevaluations;
  - Establishment of treatment goals specific to the patient’s disability or dysfunction and designed to specifically address each problem identified in the evaluation;
  - Design of a plan of care addressing the patient’s disorder, including establishment of procedures to obtain goals, determining the frequency and intensity of treatment;
  - Continued assessment and analysis during implementation of the services at regular intervals;
  - Instruction leading to establishment of compensatory skills;
  - Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system); and
  - Training of patient and family to augment rehabilitative treatment. Training of staff and family should be ongoing throughout treatment and instructions modified intermittently as the patient’s status changes.

Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services.

Rehabilitative therapy may be needed, and improvement in a patient’s condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient’s condition or to maximize his/her functional abilities. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient’s condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel.

Rehabilitative therapy is not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary and generalized weakness, which may follow a brief period of bed rest following surgery) that could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual’s illness or injury and the services are not covered.

If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, the services will no longer be considered reasonable and necessary under this section. (See Guideline 1.d below for additional covered therapy benefits under Maintenance Program). Services that are not reasonable or necessary are excluded from coverage under §1862(a)(1)(A) of the Act.

Guideline 1.d (Maintenance Program)

- Revised the statement to see the reference Medicare manual to:

  For more detailed guideline, see the Medicare Benefit Policy Manual, Chapter 15, §220.2D - Maintenance Program.

- Deleted the following (same language in the referenced Medicare Manual):

  Coverage for skilled therapy services related to a reasonable and necessary maintenance program is available in the following circumstances:
  - Establishment or design of maintenance programs. If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to
maintain the patient’s current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.

• Delivery of maintenance programs. Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary’s need for skilled care. A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided. However, skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program. Such skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the therapy procedures required to maintain the patient’s current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or (b) the particular patient’s special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient’s current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures. Unlike coverage for rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient’s potential for improvement from the therapy.

For specific examples how to analyze and determine coverage, see the Medicare Benefit Policy Manual, Chapter 15, §220.2D-Maintenance Programs. Also see 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, A-Definitions.

Guideline 1.f.1 [Comprehensive Outpatient Rehabilitation Facility (CORF)]

• Added the following:

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 guideline, see the Medicare Benefit Policy Manual, Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage.

Note: A single, home environment evaluation visit is a covered CORF service if it is included in the physical therapy, occupational therapy or speech-language pathology plan of treatment.

• Deleted the following (same language in the referenced Medicare manual):

Required Services
A CORF must furnish at least the following:

• CORF physicians’ services - includes professional services performed by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs services.

• Physical therapy services - include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached and

• Social and/or psychological services-are covered only if the patient’s physician or the CORF physician establishes that the services directly relate to the patient’s rehabilitation plan of treatment and are needed to achieve the goals in the rehabilitation plan of treatment. Social and/or psychological services include only those services that address the patient’s response and adjustment to the rehabilitation treatment plan; rate of improvement and progress towards the rehabilitation goals, or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of
treatment being provided to the patient. CORF social and/or psychological services do not include services for mental health diagnoses.

Optional Services
The CORF may provide any or all of the following rehabilitation services:

- Occupational therapy-services include assessment of an individual’s level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities.
- Speech-Language pathology-services for the diagnosis and treatment of speech and language disorders that create difficulties in communication or dysphagia (swallowing difficulties).
- Respiratory therapy - services includes only those services that can be appropriately provided to CORF patients by a qualified respiratory therapist.
- Prosthetic and orthotic devices - includes testing, fitting, or training in the use of such devices.
- Nursing – includes nursing services (e.g., teaching self catheterization) that directly relate to and are specified in the rehabilitation plan of treatment, are necessary for the attainment of the rehabilitation goals and are provided by a registered nurse.
- A single physical therapy, occupational therapy, or speech-language pathology home environment evaluation visit as appropriate – this includes evaluating the potential impact of the home environment on the rehabilitation goals.

See the Medicare Benefit Policy Manual, Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage.

Guideline 1.f.3 (Member’s place of residence)

- Added the following from the Definition section:
  
  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.
  
  See the Medicare Benefit Policy Manual, Chapter 7, §30.1.2 - Patient's Place of Residence.

- Deleted the reference link to the Coverage Summary for Home Health Services and Home Health Visits.

Guideline 2.a [Inpatient Rehabilitation Facility (IRF)]

- Revised statement to see the Medicare reference manual to:
  
  For detailed guideline, see the Medicare Benefit Policy Manual, Chapter 1, §110 - Inpatient Rehabilitation Facility (IRF) Services.

- Deleted the following (same language in the referenced Medicare manual):

  The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. (See the Medicare Benefit Policy Manual, Chapter 1, §110.2.5 - Interdisciplinary Team Approach to the Delivery of Care for the description of interdisciplinary team approach.)
  
  The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.
Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary if the patient meets all of the requirements. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.23 (b)(2) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each patient's individual care needs.

See the Medicare Benefit Policy Manual, Chapter 1, §110.2 Inpatient Rehabilitation Facility Medical Necessity Criteria.

- **Definition of Measurable Improvement:**
  A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient’s IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient’s functional condition can be accomplished within a predetermined and reasonable period of time.
  In general, the goal of IRF treatment is to enable the patient’s safe return to the home or community-based environment upon discharge from the IRF. The patient’s IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

  Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient’s admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

  For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care or return to his or her prior level of functioning. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient’s ongoing requirement for an intensive level of rehabilitation services (as defined in the Medicare Benefit Policy Manual, Chapter 1, §110.2.2 - Intensive Level of Rehabilitation Services) and an inter-disciplinary team approach to care (as defined in the Medicare Benefit Policy Manual, Chapter 1, §110.2.5 - Interdisciplinary Team Approach to the Delivery of Care). Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment.
  Since in most instances the goal of an IRF stay is to enable a patient’s safe return to the home or community-based environment upon discharge, the patient’s treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result.
  During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.

  CMS notes that as evidenced by the criteria established above, an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.

  See the Medicare Benefit Policy Manual, Chapter 1, §110.3 - Definition of Measurable Improvement.

- **Required Preadmission Screening:**
  A preadmission screening is an evaluation of the patient’s condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient’s medical and functional status within the 48 hours immediately preceding
the IRF admission in the patient’s medical record at the IRF. The preadmission screening in the patient’s IRF medical record serves as the primary documentation by the IRF clinical staff of the patient’s status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive. The preadmission screening documentation, and begin development of the patient’s expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care (as discussed in the Medicare Benefit Policy Manual, Chapter 1, §110.1.3 - Required Individualized Overall Plan of Care). The postadmission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and must include a documented history and physical exam, as well as a review of the patient’s prior and current medical and functional conditions and comorbidities.

In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the first 24 hours of admission to the IRF and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient’s medical record at the IRF. See the Medicare Benefit Policy Manual, Chapter 1, §110.1.2 - Required Post-Admission Physician Evaluation.

- Deleted the following duplicate reference links:
  - Medicare Benefit Policy Manual, Chapter 1, §110.1.3 – Required Individualized Overall Plan of Care
  - Medicare Benefit Policy Manual, Chapter 1, §110.2.1 – Multiple Therapy Disciplines.

Guideline 3 (Cognitive Therapy) – deleted the following as this section has been deleted:

For CORF, required and optional services, refer to Guideline 1.f.1 [Comprehensive Outpatient Rehabilitation Facility (CORF)] above.

Guideline 4 [Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)] - deleted the following note; PAD is no longer considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations; see CY 2019 MA Capitation Rates and Part D Payment Policies.

CMS has determined that the National Coverage Determination requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2017 and 2018 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans. (Per HPMS e-mail distribution dated April 10, 2018)

Guideline 5 (Rehabilitation Services for Members with Vision Impairment) - updated statement that LCDs are available to a general statement; delete specific LCD title.

Guideline 6.a (Aqua/pool therapy/hydrotherapy) – added a general statement that LCDs are available.

Guideline 6.b (Fluidized Therapy) – added a general statement that LCDs are available.

Guideline 6.c (Treatment of Dysphagia) – added a general statement that LCDs are available.

Guideline 6.d [Diathermy Treatment (CPT code 97024 and 97035)] – updated statement that LCDs are available to a general statement; delete specific LCD titles.

Definitions:
- Physician Supervision - deleted; language can be accessed in the same Medicare
• Place of Residence – moved to Guideline 1.f.3
• Qualified Physical or Occupational Therapist – deleted; already included in the definition of Qualified Professional
• Qualified Speech-Language Pathologist – deleted; already included in the definition of Qualified Professional

04/01/2019

• Updated policy introduction; added language to clarify:
  o There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
  o In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5)

• Retitled reference link that directs users to UnitedHealthcare Commercial policy

4/17/2018

Annual review with the following updates:

Guideline 1.f.1 Comprehensive Outpatient Rehabilitation Facility (CORF) – deleted the following references (not needed as same references are also included in the applicable reference Medicare manuals): “See the 42CFR410.100(h) and the Medicare Benefit Policy Manual, Chapter 12, §40.1”

Guideline 4 (Melodic Intonation Therapy) - moved under new Guideline 6 (Other Examples of Rehabilitation Therapy Services)

Guideline 5 (Passive Rehab Therapy for Mandibular Hypermobility) - moved under new Guideline 6 (Other Examples of Rehabilitation Therapy Services)

Guideline 6 (Comprehensive Computer-Based Motion Analysis) – deleted guideline as the default UHC Medical Policy for Gait Analysis will be retired effective June 1, 2018; there are no available LCDs; not listed in the Prior Notification List.

Guideline 9 (Examples of covered rehabilitation therapy services include but are not limited to)
  • Deleted this section title and move examples under the new Guideline 6 (Other Examples of Rehabilitation Therapy Services)
  • Deleted (a) Range of motion tests, (b) Gait training and (c) therapeutic exercises – no specific Medicare reference

Guideline 10 (Examples of rehabilitation services that are not covered or with limited coverage, include but are not limited to) – deleted this section title and move examples under the new Guideline 6 (Other Examples of Rehabilitation Therapy Services)

Guideline 6 (Other Examples of Rehabilitation Therapy Services) - Added new section title to include all other example of rehabilitation therapy services

Definitions
  • Deleted the following definitions (already included in the applicable reference Medicare manuals or NCD; applicable Medicare manual links to the definitions added in the body of the guidelines):
UHC MA Coverage Summary: Rehabilitation: Medical Rehabilitation (OT, PT and ST, Including Cognitive Rehabilitation)

- Fluidized therapy (Fluidotherapy)
- Individual Patient Care Plan (Overall Care Plan)
- Intensive Level of Rehabilitation
- Interdisciplinary Team Approach
- Melodic Intonation Therapy

- Updated the definition of Therapy Services to read:

  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.

03/20/2018 Re-review with the following updates:

Guideline 7 [Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CPT code 93668)] - deleted the detailed guideline which was based on the Decision Memo issued on May 25, 2017 and replace with the following coverage statement with a reference link to the final NCD for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35).

  Supervised exercise therapy (SET) for members with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD) is covered when criteria are met. See the NCD for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35).

Guideline 8 (Rehabilitation Services for Members with Vision Impairment) – added guideline; moved from the Coverage Summary for Vision Services, Therapy and Rehabilitation.

11/20/2017 Re-review with the following update:

Guideline 3 (Cognitive Therapy) - Removed reference to CPT code 97532 (code deleted effective January 1, 2018)

08/15/2017 Re-review with the following updates:

- Added the following note per the HPMS e-mail distribution dated August 11, 2017:

  CMS has determined that the National Coverage Determination requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. As a result, for calendar years 2017 and 2018 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans.

- Added CPT code 93668

06/21/2017 Re-review; added Guideline 7 [Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)] (new to the policy); guideline based on the May 25, 2017 CMS Decision Memo for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CAG-00449N).

05/16/2017 Annual review with no updates.

04/19/2016 Annual review with the following update:

Guideline # 8 (Examples of rehabilitation services that are not covered or with limited
coverage, include but are not limited to) – Added “Home Health Physical Therapy” to list of LCDs that address diathermy treatment.

07/21/2015 Guideline 7.a (Ultrasound, shortwave, and microwave diathermy treatments)
- Moved to Guideline 8.a
Guideline 8.a (Diathermy Treatment)
- Guideline moved from Guideline 7.a; updated with the addition of the guideline from the retired Coverage Summary titled Diathermy Treatment

06/16/2015 Guideline 8.a [Sensory Integration Therapy (CPT Code 97533)] - Removed guideline; no longer included in the Prior Notification List.

04/21/2015 Annual review with the following update:
Guideline 7 (Comprehensive Computer-based Motion Analysis) - Changed default guideline for states with no LCDs from First Coast Services Options (MAC Part B) L29116 to UnitedHealthcare Medical Policy for Gait Analysis.

04/15/2014 Annual review; Guideline #6 (Passive Rehab Therapy for Mandibular Hypomobility) - Title of the default policy, i.e., UnitedHealthcare Medical Policy, changed from Mandibular Disorders to Temporomandibular Joint Disorders

02/18/2014 Additional updates to the Coverage Summary made to align with the Medicare Benefit Policy Manual updates in accordance with the Jimmo v. Sebelius Settlement Agreement; CMS Transmittal 179, January 14, 2014, Change Request 8458.


10/24/2013 Guideline #1 (Outpatient Rehabilitation Therapy) - Updated based on the Medicare Benefit Policy Manual Chapter 15, Section 220 Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance.
Guideline #2 (Inpatient Rehabilitation Services) - Deleted the following language under #2.a: Coverage stops when further progress toward the established rehabilitation goal is unlikely or when further progress can be achieved in a less intensive setting. Both the degree of improvement and the type of program needed to achieve further improvement must be considered.

04/29/2013 Annual review with the following updates:
- Added a note pertaining to the January 24, 2013 court approval of settlement agreement in the case of Jimmo v. Sebelius.
- Guidelines #6 (Complex Decongestive Physiotherapy) - Replaced the default guidelines for states with no LCDs from Trailblazer LCD for Complex Decongestive Physiotherapy (CDP) for Lymphedema (L26710) (retired) to Novitas LCD for Complex Decongestive Physiotherapy (CDP) for Lymphedema (L32698)

10/31/2012 Updated to include Guidelines #9 - Comprehensive Computer-based Motion Analysis.

04/23/2012 Annual review; Guidelines #2.b.1 (Comprehensive Outpatient Rehabilitation
Facility/CORF) – added the sections, Required Services and Optional Services.

12/19/2011 Guidelines #6 (Complex Decongestive Physiotherapy/CDP) updated, i.e., deleted L18473 as guidelines reference for states with no LCDs as this LCD was retired.

04/26/2011 Annual review with the following updates:

- Guidelines #2.a.1 (Inpatient Rehabilitation Facility (IRF) Services) – updated to include information pertaining to preadmission screening and post-admission physician evaluation.
- Guidelines #2.b.1 (Comprehensive Outpatient Rehabilitation Facility/CORF) – updated to include a note pertaining to home evaluation visit.
- Guidelines #5 (Cognitive Therapy) – deleted the guidelines based on the TriSpan Local Article A36213 (retired); updated to include cognitive therapy coverage language based on the Medicare Benefit Policy Manual, Chapter 12, § 40.3 Occupational Therapy Services; also added references and links to the available LCDs.
- Guidelines #6 (Complex Decongestive Physiotherapy) – updated using the standard CS format.

08/24/2010 Note pertaining to therapy caps updated; the Medicare therapy caps does not apply to UnitedHealthcare MedicareComplete and UnitedHealthcare MedicareDirect plans.