

## Rehabilitative Services

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This section contains information to assist providers in billing for rehabilitative services such as physical, occupational and speech therapy.

### **Billing for Preliminary Evaluation**

The billing codes listed below have been established by the Department of Health Care Services (DHCS) for use in billing preliminary and six-month evaluation visits for physical therapy, occupational therapy, speech pathology and audiology services performed in outpatient rehabilitation centers, Nursing Facility Level B (NF-B) or Nursing Facility Level A (NF-A) only.

The purpose of the preliminary evaluation visits should be to evaluate the patient for a particular type of therapy and to prepare an extended treatment plan. The purpose of the six-month evaluation visit is to update the plan. These codes are not to be used to bill for evaluation or re-evaluation during an ongoing course of treatment.

<b>Type of Therapy</b>	<b>HCPCS Code</b>	<b>Description</b>
Physical Therapy	X3924	Preliminary evaluation visit in rehabilitation center, NF-B or NF-A
Occupational Therapy	X4108	Preliminary evaluation visit in rehabilitation center, NF-B or NF-A
Audiology	X4502	Preliminary evaluation visit in rehabilitation center, NF-B or NF-A
Speech Pathology	X4308	Preliminary evaluation visit in

### **Rehabilitation Centers**

These codes may be used for billing for preliminary evaluations by rehabilitation center providers without prior authorization, no more than once in a 180-day period with the exception of HCPCS code X3924 (physical therapy), which requires prior authorization regardless of Place of Service.

### **Independent Practitioners**

These codes, with the exception of physical therapy (X3924), may be billed for preliminary evaluation of patients in an NF-A or NF-B using a proof of eligibility and do not require prior authorization.

## Hospital Outpatient Departments and Organized Outpatient Clinics

Hospital outpatient departments and organized outpatient clinics are subject to the same restrictions as independent practitioners and cannot bill as rehabilitation centers unless specifically licensed as a rehabilitation center.

### Prior Authorization

Services billed by a rehabilitation center must have prior authorization with the exception of initial and six-month evaluations.

### Initial and Six-Month Billing Codes

Procedure codes for billing initial and six-month evaluations in specific therapies are:

HCPCS Code	Description
X4108	Occupational Therapy
X4502	Audiology
X4308	Speech Pathology

**Notes:** All physical therapy services, including HCPCS code X3924 (initial and six-month evaluation), require prior authorization regardless of Place of Service.

All therapy services rendered in a rehabilitation center must be billed by the center.

### Authorization: Extended Treatment Plan Required

Requests for authorization should be submitted to the TAR Processing Center and must be accompanied by an extended treatment plan signed by a physician. The extended treatment plan must include:

- The principal and significant associated diagnoses,
- Date of onset of illness or injury,
- Current medical condition necessitating the services,
- Specific type, number, and frequency of services to be rendered by each discipline,
- Therapeutic goals to be achieved by each discipline and the anticipated time required to achieve these goals and
- The extent to which physical, occupational and speech therapy or audiology services have been previously provided, and benefits or improvements demonstrated by such care.

The Medi-Cal program definition of medical necessity limits the provision of health care services to those that are reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain.

Authorization may be granted when the services requested are reasonably expected to:

- Restore lost functions, or
- Minimize deterioration of existing functions, or
- Provide necessary training in the use of orthotic or prosthetic devices, or
- Provide the capability for self care, including feeding, toilet activities, and ambulation; and
- When failure to achieve such goals would result in loss of life or significant disability.

### **Facility Type/Place of Service Code**

For claims with dates of service on or after September 22, 2003, national facility type code “74” for Clinic – Outpatient Rehabilitation Facility (ORF) and “75” for Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF) must be used. For dates of service prior to September 22, 2003, Place of Service code “9” must be used, and is applicable to both ORF and CORF.

Services to patients in a Skilled Nursing – Intermediate Care Level II (NF-B) facility must be billed using facility type code “26.”

Services to patients in a Skilled Nursing – Intermediate Care Level II (NF-A) facility must be billed using facility type code “25.”

### **Cardiovascular Rehabilitation**

Cardiovascular rehabilitation/intensive cardiovascular rehabilitation (ICR) is reimbursable under Medi-Cal with the following conditions.

## Patient Eligibility for Outpatient Cardiovascular Rehabilitation

Patients are eligible for outpatient cardiovascular rehabilitation/ICR if they have experienced one or more of the following:

- Acute coronary syndrome within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Percutaneous transluminal coronary angioplasty or coronary stenting;
- A heart or heart-lung transplant;
- Intermittent claudication due to atherosclerotic disease; or
- Stable chronic heart failure. “Chronic heart failure” is defined as left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II-IV symptoms despite being on optimal heart failure therapy for at least six weeks. “Stable” is defined as no recent (six months or earlier) major cardiovascular hospitalizations or procedures.

Because evidence of safety and efficacy for patients with NYHA class IV heart failure is sparse, cardiovascular rehabilitation/ICR programs must consider whether these patients, as well as those with major comorbidities or limitations that would prevent safe and efficient completion of exercise training, should be excluded from participation when establishing individualized treatment plans.

## Cardiovascular Rehabilitation/ ICR Program Component Requirements

In order to receive reimbursement, cardiovascular rehabilitation and ICR programs must include the following components:

- Physician-prescribed exercise – this physical activity includes aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual patients by a physician each day that cardiovascular rehabilitation/ICR services are furnished.

The prescription should include:

- Mode of exercise
- Target intensity
- Duration of each session
- Frequency of sessions per week

Documentation of each day of therapy should include:

- Whether the prescription was carried out,
  - A reasonable clinical explanation if the exercise prescription was not carried out, and
  - The signature and credentials of the individual who directly supervised the exercise.
- Outcomes assessment – these should include:
    - At minimum, assessments from the commencement and conclusion of cardiovascular rehabilitation/ICR, based on patient-centered outcomes which must be measured by the physician immediately at the beginning and end of the program, and
    - Objective clinical measures of the effectiveness of the cardiovascular rehabilitation/ICR program for the individual patient, including exercise performance and self-reported measures of exercise tolerance. The clinician performing the assessment must sign these notes with his or her credentials on the day the assessment was performed.
  - An individualized treatment plan – this plan should be recorded in the patient’s medical record within one week after the patient first receives cardiovascular rehabilitation services. The plan should be tailored to each patient and include:
    - A description of the patient’s diagnosis,
    - The type, amount, frequency and duration of the cardiovascular rehabilitation/ICR services furnished, and
    - The exercise goals set for the patient under the plan. The individualized treatment plan must be established, reviewed and signed by a physician every 30 days.

Further documentation must be provided by the treating physician at least every 30 days which describes the outcomes assessment and any modifications needed in the plan of care previously prescribed, or the reason(s) to continue the present plan.

### **Cardiovascular Rehabilitation/ ICR Sessions Frequency Limitations**

Only cardiovascular rehabilitation sessions that are exercise-based are reimbursable. Cardiovascular rehabilitation exercise sessions are limited to a maximum of two one-hour sessions per day (up to 24 sessions, over a period of up to 24 weeks) for any provider. An additional 24 sessions may be reimbursed with a *Treatment Authorization Request (TAR)* if medically necessary.

A TAR must be submitted if further sessions are requested and must include documentation that:

- Progress has been made in meeting the goals of the individualized treatment plan but these goals have not been fully met, and
- The patient is compliant with the program.

ICR sessions that are reimbursable may include any of the following components:

- Supervised physical exercise
- Cardiovascular risk factor modification
- Psychosocial assessment

ICR sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks for any provider.

Each new qualifying cardiovascular event provides medical necessity for a new course of cardiovascular rehabilitation/ICR.

### **Cardiovascular Rehabilitation/ ICR Program Setting Requirements**

Cardiovascular rehabilitation/ICR services must be furnished in a physician's office or hospital outpatient setting. For ICR, the hospital outpatient setting must provide ICR within an ICR program approved by the Centers for Medicare & Medicaid Services (CMS).

All settings must have a physician physically present and immediately available and accessible for medical consultations and emergencies at all times when services are being furnished under the program.

### **Cardiovascular Rehabilitation/ ICR Program Physician Requirements**

Physicians responsible for cardiovascular rehabilitation/ICR programs must be identified as medical directors who oversee or supervise the cardiovascular rehabilitation/ICR program at a particular site.

The medical director, in consultation with staff, must be involved in directing the progress of patients in the program.

The medical director, as well as physicians acting as the supervising physician, must possess all of the following:

- Expertise in the management of patients with cardiovascular pathophysiology
- Cardiopulmonary training in basic life support or advanced cardiac life support
- A license to practice medicine in the state in which the cardiovascular rehabilitation/ICR program is offered. Direct physician supervision may be provided by a supervising physician or the medical director.

## ICR Program Approval Requirements

All prospective ICR programs must be approved by CMS through the national coverage determination (NCD) process.

For detailed information on obtaining CMS approval see the *Code of Federal Regulations* (CFR), Title 42, Section 410.49.

A list of approved ICR programs, identified through the NCD process, can be found on the CMS website and in the Federal Register.

## Billing Requirements

Professional claims for cardiac rehabilitation containing the following CPT® and HCPCS codes are reimbursable:

CPT Code	Description
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitor (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

HCPCS Code	Description
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session

CPT codes 93797 and 93798 may not be reimbursed in the same calendar month as HCPCS codes G0422 and G0423, for any provider. Similarly, HCPCS codes G0422 and G0423 may not be reimbursed in the same calendar month as CPT codes 93797 and 93798, for any provider.

**Note:** For a comprehensive and updated list of non-reimbursable components, providers should refer to the CPT and HCPCS code books, and the National Correct Coding Initiative (NCCI) when billing.

Providers may bill CPT codes 93797 and 93798 for a maximum of two one-hour sessions of cardiovascular rehabilitation per day and up to 24 one-hour sessions over a 24-week period. The combined total number of sessions billed with CPT codes 93797 and 93798 must not exceed 24 in a 24-week period. A TAR may be used to override the frequency limit.

Providers may bill HCPCS codes G0422 and G0423 for a maximum of six one-hour sessions of intensive cardiovascular rehabilitation per day and up to 72 one-hour sessions over an 18-week period. The combined total number of sessions billed with HCPCS codes G0422 and G0423 must not exceed 72 in an 18-week period. A TAR may not be used to override the frequency limit.

### Qualified Practitioners

Licensed practitioners who are eligible for reimbursement of CPT codes 93797 and 93798 include physicians, physician assistants, nurse practitioners and physical therapists.

Licensed practitioners who are eligible for reimbursement of HCPCS codes G0422 and G0423 include physicians, physician assistants, nurse practitioners, psychologists, licensed clinical social workers, marriage and family therapists and physical therapists.

### ICD-10-CM Diagnosis Codes

When billing for CPT codes 93797 and 93798 or HCPCS codes G0422 and G0423, the claim must include one of the following:

I20.1 thru I22.9	I25.761 thru I25.769	I70.411 thru I70.413
I25.111 thru I25.119	I25.791 thru I25.799	I70.511 thru I70.513
I25.701 thru I25.709	I50.22	I70.611 thru I70.613
I25.711 thru I25.719	I50.32	I70.711 thru I70.713
I25.721 thru I25.729	I50.42	Z95.1
I25.731 thru I25.739	I70.211 thru I70.213	Z95.5
I25.751 thru I25.759	I70.311 thru I70.313	Z98.61

## **TAR Requirements**

A TAR is required for intensive cardiac rehabilitation program services (HCPCS codes G0422 and G0423). A TAR approval requires documentation that a patient meets diagnostic criteria for cardiovascular rehabilitation, and that the program is a CMS-approved ICR program.

## **Pulmonary Rehabilitation**

For information about pulmonary rehabilitation, refer to the “Pulmonary Rehabilitation” heading in the *Respiratory Care* section of this manual.

## **<<Legend>>**

<<Symbols used in the document above are explained in the following table.>>

<b>Symbol</b>	<b>Description</b>
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.