

rate of progress as it relates to the individual's rehabilitation plan of treatment, including physical therapy services, occupational therapy services, speech-language pathology services and respiratory therapy services.

(i) *Nursing care services.* Nursing care services include nursing services provided by a registered nurse that are prescribed by a physician and are specified in or directly related to the rehabilitation treatment plan and necessary for the attainment of the rehabilitation goals of the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment.

(j) *Drugs and biologicals.* These are drugs and biologicals that are the following:

(1) Prescribed by a physician and administered by or under the supervision of a physician or by a registered professional nurse; and

(2) Not excluded from Medicare Part B payment for reasons specified in § 410.29.

(k) *Supplies and durable medical equipment.* Supplies and durable medical equipment include the following:

(1) Disposable supplies.

(2) Durable medical equipment of the type specified in § 410.38 (except for renal dialysis systems) for a patient's use outside the CORF, whether purchased or rented.

(l) *Home environment evaluation.* A home environment evaluation—

(1) Is a single home visit to evaluate the potential impact of the home situation on the patient's rehabilitation goals.

(2) Requires the presence of the patient and the physical therapist, occupational therapist, or speech-language pathologist, as appropriate.

[51 FR 41339, Nov. 14, 1986; 52 FR 4499, Feb. 12, 1987, as amended at 72 FR 66399, Nov. 27, 2007]

§ 410.102 Excluded services.

None of the services specified in § 410.100 is covered as a CORF service if the service—

(a) Would not be covered as an inpatient hospital service if furnished to a hospital inpatient;

(b) Is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the func-

tioning of a malformed body member. An example would be services furnished as part of a maintenance program involving repetitive activities that do not require the skilled services of nurses or therapists.

§ 410.105 Requirements for coverage of CORF services.

Services specified in § 410.100 and not excluded under § 410.102 are covered as CORF services if they are furnished by a participating CORF (that is, a CORF that meets the conditions of subpart B of part 485 of this chapter, and has in effect a provider agreement under part 489 of this chapter) and if the following requirements are met:

(a) *Referral and medical history.* The services must be furnished to an individual who is referred by a physician who certifies that the individual needs skilled rehabilitation services, and makes the following information available to the CORF before or at the time treatment is begun:

(1) The individual's significant medical history.

(2) Current medical findings.

(3) Diagnosis(es) and contraindications to any treatment modality.

(4) Rehabilitation goals, if determined.

(b) *When and where services are furnished.* (1) All services must be furnished while the individual is under the care of a physician.

(2) Except as provided in paragraph (b)(3) of this section, the services must be furnished on the premises of the CORF.

(3) *Exceptions.* (i) Physical therapy, occupational therapy, and speech-language pathology services may be furnished away from the premises of the CORF including the individual's home when payment is not otherwise made under Title XVIII of the Act.

(ii) The single home environment evaluation visit specified in § 410.100(m) is also covered.

(c) *Plan of treatment.* (1) The service must be furnished under a written plan of treatment that—

(i) Is established and signed by a physician before treatment is begun; and

(ii) Prescribes the type, amount, frequency, and duration of the services to

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be furnished, and indicates the diagnosis and anticipated rehabilitation goals.

(2) The plan must be reviewed at least every 60 days for respiratory therapy services and every 90 days for physical therapy, occupational therapy and speech-language pathology services by a facility physician or the referring physician who, when appropriate, consults with the professional personnel providing the services.

(3) The reviewing physician must certify or recertify that the plan is being followed, the patient is making progress in attaining the rehabilitation goals, and the treatment is having no harmful effects on the patient.

(d) *Claims.* Effective for dates of service on and after January 1, 2020 physical therapy or occupational therapy services covered as part of a rehabilitation plan of treatment described in paragraph (c) of this section, as applicable—

(1) Claims for such services furnished in whole or in part by a physical therapist assistant or an occupational therapy assistant must be identified with the inclusion of the respective prescribed modifier; and

(2) Effective for dates of service on and after January 1, 2022, such claims are paid an amount equal to 85 percent of the amount of payment otherwise applicable for the service as defined at section 1834(k) of the Act.

(3) For purposes of this paragraph, “furnished in whole or in part” means when the physical therapist assistant or occupational therapy assistant either—

(i) Furnishes all the minutes of a service exclusive of the respective physical therapist or occupational therapist; or

(ii) Except as provided in paragraph (d)(3)(iii) of this section, furnishes a portion of a service, or in the case of a 15-minute (or other time interval) timed code, a portion of a unit of service, separately from the part furnished by the physical or occupational therapist such that the minutes for that portion of a service (or unit of a service) exceed 10 percent of the total time for that service (or unit of a service).

(iii) Paragraph (d)(3)(ii) of this section does not apply when determining

whether the prescribed modifier applies to the last 15-minute unit of a service billed for a patient on a treatment day when the physical or occupational therapist provides more than the midpoint of a 15-minute timed code, that is, 8 or more minutes, regardless of any minutes for the same service furnished by the physical therapist assistant or occupational therapy assistant.

(iv) Where there are two remaining 15-minute units to bill of the same service and the physical therapist and the physical therapist assistant or the occupational therapist and the occupational therapy assistant, as applicable, each provided between 9 and 14 minutes, with a total time of at least 23 minutes, one unit of the service is billed with the prescribed modifier for the minutes furnished by the physical therapist assistant or occupational therapy assistant and one unit is billed without the prescribed modifier for the service provided by the physical therapist or occupational therapist.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 8841, Mar. 1, 1991; 72 FR 66400, Nov. 27, 2007; 77 FR 69363, Nov. 16, 2012; 83 FR 60073, Nov. 23, 2018; 84 FR 63191, Nov. 15, 2019; 86 FR 65666, Nov. 19, 2021]

Subpart E—Community Mental Health Centers (CMHCs) Providing Partial Hospitalization Services and Intensive Outpatient Services

§ 410.110 Requirements for coverage of partial hospitalization services by CMHCs.

Medicare part B covers partial hospitalization services furnished by or under arrangements made by a CMHC if they are provided by a CMHC as defined in § 410.2 that has in effect a provider agreement under part 489 of this chapter and if the services are—

(a) Prescribed by a physician and furnished under the general supervision of a physician;

(b) Subject to certification by a physician in accordance with § 424.24(e)(1) of this subchapter; and

(c) Furnished under a plan of treatment that meets the requirements of § 424.24(e)(2) of this subchapter.

[59 FR 6577, Feb. 11, 1994]