Direct Access and Medicare

Medicare beneficiaries are able to go directly to physical therapists (PT) without a referral or visit to a physician. This policy became effective in 2005 through revisions to the Medicare Benefit Policy Manual (Publication 100-02).

In the past, the Centers for Medicare and Medicaid Services (CMS) required a physician visit within 60 days of the initial visit and at 30 day intervals thereafter to continue therapy services. The 2005 revisions eliminated the physician visit requirement. A patient must be “under the care of a physician” which is indicated by the physician certification of the plan of care. A summary of the 2005 revisions can be found at this link.

The following information is offered to help physical therapists provide access to PT services to patients and remain in compliance with laws and regulations. For more detailed information on CMS requirements, review section 220.1.1-3 of the Medicare Benefits Policy Manual and national and local coverage determinations. A podcast on this topic is available: http://www.apta.org/Podcasts/2012/8/8/.

What the rules say:

- PTs must comply with the laws in their state related to the need for a referral for physical therapy. Review your state practice act at this link.
- The plan of care developed by the PT must be certified by a physician or non-physician practitioner (NPP) as soon as possible or within 30 days of the initial therapy visit.
- The plan of care must include, at a minimum, (1) diagnoses; (2) long term treatment goals; and (3) type, amount, and duration of therapy services.
- Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. Stamped signatures are not acceptable. If the order to certify is verbal, it must be followed within 14 days by a signature.
- Medicare does not require that the patient visit the physician/NPP. However, a physician/NPP may require the visit.
- Medicare does not require a physician order for physical therapy services.
- Recertification of the plan of care is required if a patient’s condition changes requiring revision of long term goals or within 90 calendar days from the date of the initial treatment, whichever is first.

What this means for PTs:

In order to be paid by Medicare for the services, practices should have procedures in place to ensure that the plan of care is certified. Medicare does not require certification of the plan of care before treatment is initiated. However, if the PT does not have a relationship with the physician or is not confident that the physician will sign the plan of care, it may be prudent for the PT to contact the physician for verbal authorization before initiating treatment. If state law is more restrictive that Medicare regulations, physical therapists must comply with state law.
It is important to point out that several states have additional laws that may impact the delivery of services in hospital-based settings. It is necessary for physical therapists to be aware of laws and regulations that govern not only the practice of physical therapy but also the delivery of services in hospitals. State departments of health often have laws and regulations that govern hospital practice. Compliance departments in hospitals should be helpful during this process.

**What this means for PTs:**

In hospital-based outpatient settings, when direct access is permissible by state law, physical therapists should request written approval by the governing body of the hospital to include physical therapists on the list of practitioners who meet the hospital’s policies for ordering and referring patients to hospital outpatient therapy services.

APTA’s audio course, [Hospital Based Direct Access](#), should be useful to physical therapists who wish to integrate direct access into their hospital outpatient practices.

**Filing Medicare claims under direct access:**

Medicare regulations specify how to report information on the certifying physician/NPP on claims for outpatient therapy services.

- Effective October 1, 2012, providers must report the name and NPI number of the certifying physician/NPP on the claim for therapy services.
- For claims processing purposes, the certifying physician/NPP is considered a referring provider. The term “referring provider” is used by Medicare in this case simply because this is the term that is currently on the claim form.
- The use of the term “referring provider” does not change existing regulations stating that Medicare does not require a patient visit with the physician/NPP.

**Case Scenarios:**

The following vignettes provide descriptions of patient and practice management for Medicare beneficiaries who access physical therapy services via direct access:

**Case Scenario 1**

The patient is a 70 year old female who awoke this morning with an acute vestibular disorder resulting in severe nausea and dizziness. The hospital’s bylaws include PTs on the list of providers who can order rehabilitation so a referral from a physician is not required by either the hospital or by Medicare. Direct access to physical therapy is allowed by state law.

The PT performs an examination and evaluation and establishes a diagnosis, prognosis and plan of care for the patient and proceeds with interventions to treat the patient’s condition.

Following the initial treatment, the PT telephones the office of the patient’s physician to report that he has seen the patient and briefly describes his findings and plan for the patient. Although this step is not
required, the PT believes that this communication is in the best interest of the patient. He tells the
physician’s office that a detailed report and plan of care will be forthcoming.

The plan of care is sent to the physician who signs it and sends it back in the self-addressed return
envelope that the PT department provided for easy return. The patient is seen for one additional visit
and is discharged with symptoms resolved. A copy of the discharge summary is forwarded to the
physician so that the patient’s medical record can reflect the patient’s status at discharge.

**Case Scenario 2**
The patient is a 75 year old male who reports increasing difficulty getting in and out of a chair and car
and describes occasional difficulty with balance when walking on uneven surfaces. The patient had a
CVA 3 years ago and received physical therapy at a rehabilitation facility in the area at that time. His
neighbor suggested that he see the PT at a local private practice for help with these new problems.

The PT performs an examination and evaluation and establishes a diagnosis, prognosis and plan of care
for the patient. Intervention during the initial visit focuses on safety issues related to falls prevention,
safe and effective sit to stand strategies, and strengthening exercises for the hip and knee muscles.

Before the second appointment, the physical therapist contacts the physician by email to inform him
that she has seen the patient, provides a brief description of findings and plan of care, and indicates that
a report and plan of care will be forthcoming. The physician responds that he agrees with the treatment
plan. However, two reminder calls are required before the physician signs and returns the plan of care.
The patient has a good outcome with treatment and is discharged after 6 visits. A discharge summary is
sent to the physician to communicate the patient’s response to care.

**Case Scenario 3**
The patient is a 78 year old male who experienced a fall in his home two days ago. His son found the
practice through an internet search and has brought his father to PT. The patient has a primary care
physician but has not seen him in two years. He has been unable to bear weight on the left leg and has
localized tenderness and edema over the patella. His medical history includes diabetes which is poorly
controlled, hypertension, and prostate cancer.

The PT takes a detailed medical history and performs a brief examination of the patient. Because of the
medical history, the trauma from the fall and the lack of medical management of his chronic conditions,
the PT determine that the patient is not appropriate for PT interventions until he has been seen by his
physician.

The PT phones the patient’s physician, describes the findings, and recommends that the patient have x-
rays and a medical consult before initiating PT interventions. The x-rays are ordered by the patient’s
physician and the physician is able to see the patient that day to evaluate and help stabilize his medical
condition. X-rays are negative and the patient returns to PT 2 days later. At this time, the PT completes
the evaluation and examination and establishes a diagnosis, prognosis and plan of care. The plan of care
is forwarded to the physician who signs it and returns it to the practice.

The patient is seen for 8 visits for treatment to improve strength and balance. He is referred to a falls
prevention program at the local YMCA. A discharge summary including information about the referral
to the falls program is sent to the physician following discharge.