

**Educational Summary of Pre-Pay Probe FBW1H  
Occupational Therapy Services Provided in a Skilled Nursing Facility  
CPT 97004**

As a Medicare contractor, NHIC performs data analysis and complex medical review of services billed to the Medicare Trust Fund. Recent review of occupational therapy services reported with bill types 22X and 23X has indicated the need for widespread education.

The following issues were identified for providers involved in the review.

Denial reason codes with definitions:

56900- records not returned timely

Providers are required to return requested records within 30 days of the date the Additional Development Request (ADR) is generated. If the documentation is not received by the 45<sup>th</sup> day an automated denial 56900 is affixed to the claim.

55B12- documentation did not support the medical necessity of the service.

Documentation of therapy services is required to meet all medical necessity and skilled therapy requirements as outlined in the Outpatient Physical and Occupational Therapy Local Coverage Determination (LCD), L29833.

55B30- the claim was denied after review and it was determined that the services billed were not documented in the records.

55B31 - the claim was denied after review and it was determined that the documentation needed to make payment was missing/incomplete (ex. Incomplete documentation to support therapy units billed).

55S00 - medical review denial due to missing/incomplete documentation.

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Recommendations for supportive documentation and minimum documentation requirements are outlined in LCD L29833. Each CPT/HCPCS code listed in the policy contains supportive documentation information after the description of the code. Documentation requirements are included under the General Information area at the end of the policy. All reported services must be supported as provided at the level billed.

*Re-evaluation documentation must include clear justification for the need for further tests and measurements after the initial evaluation, such as new clinical findings, a significant, unanticipated change in the patient's condition, or failure to respond to the interventions in the plan of care. It is expected that clinicians continually assess the patient's progress as part of the ongoing therapy services. This assessment is not considered a formal re-evaluation; the time of any assessment is included and billed within the appropriate treatment intervention CPT code.*

*Re-evaluations must be performed by clinicians and contain all applicable components of the initial evaluation. Resolved problems do not need to be re-evaluated; new or ongoing problems may need to be re-evaluated, especially if there is an anticipated change to the long term goals.*

55B15 - The claim was denied after review and it was determined that the physician order for the service billed was not present.

LCD L29833 states:

*Medicare beneficiaries receiving outpatient therapy services must be under the care of a physician/NPP. Orders (sometimes called referrals) and certifications are common means of demonstrating such evidence of physician involvement.*

The NHIC Local Coverage Determinations for Part A services can be found at:

[www.MedicareNHIC.com](http://www.MedicareNHIC.com)

J14 MAC Part A

[LCDs/Policy Indices](#)

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