CMS Manual System

Pub 100-03 Medicare National Coverage Determinations

Transmittal 55

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MAY 5, 2006

Change Request 4014

SUBJECT: Changes Conforming to CR3648 for Therapy Services

I. SUMMARY OF CHANGES: These changes update language. For example the term 'speech therapy' has been obsolete since 1972 and should be 'speech-language pathology.' Requirements for therapy services incident to a physician have not been changed.

NEW/REVISED MATERIAL
EFFECTIVE DATE: October 1, 2006
IMPLEMENTATION DATE: October 2, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/2/160.12 - Neuromuscular Electrical Stimulator(NMES)
R	1/3 - Table of Contents
R	1/3/170.3 - Speech-Language Pathology Services for the Treatment of Dysphagia
R	1/4/290.1 - Home Health Visits to a Blind Diabetic

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Medicare National Coverage Determinations Manual

Chapter 1, Part 2 (Sections 90 – 160.25)

Coverage Determinations

(Rev. 55, 05-05-06)

160.12 - Neuromuscular Electrical Stimulator (NMES)

(Rev. 55, Issued: 05-05-06, Effective: 10-01-06, Implementation: 10-02-06)

Neuromuscular electrical stimulation (NMES) involves the use of a device which transmits an electrical impulse to the skin over selected muscle groups by way of electrodes. There are two broad categories of NMES. One type of device stimulates the muscle when the patient is in a resting state to treat muscle atrophy. The second type is used to enhance functional activity of neurologically impaired patients.

Treatment of Muscle Atrophy

Coverage of NMES to treat muscle atrophy is limited to the treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). (See §160.13 for an explanation of coverage of medically necessary supplies for the effective use of NMES.)

Use for Walking in Patients with Spinal Cord Injury (SCI)

The type of NMES that is use to enhance the ability to walk of SCI patients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. Coverage for the use of NMES/FES is limited to SCI patients for walking, who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months. The trial period of physical therapy will enable the physician treating the patient for his or her spinal cord injury to properly evaluate the person's ability to use these devices frequently and for the long term. Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program. .

The goal of physical therapy must be to train SCI patients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

Coverage for NMES/FES for walking will be covered in SCI patients with all of the following characteristics:

1. Persons with intact lower motor unite (L1 and below) (both muscle and peripheral nerve);

2. Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;

3. Persons that demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction;

4. Persons that possess high motivation, commitment and cognitive ability to use such devices for walking;

5. Persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;

6. Persons that can demonstrate hand and finger function to manipulate controls;

7. Persons with at least 6-month post recovery spinal cord injury and restorative surgery;

8. Persons with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and

9. Persons who have demonstrated a willingness to use the device long-term.

NMES/FES for walking will not be covered in SCI patient with any of the following:

1. Persons with cardiac pacemakers;

2. Severe scoliosis or severe osteoporosis;

3. Skin disease or cancer at area of stimulation;

4. Irreversible contracture; or

5. Autonomic dysflexia.

The only settings where therapists with the sufficient skills to provide these services are employed, are inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of a one-on-one training program.

Additional therapy after the purchase of the DME would be limited by our general policies in converge of skilled physical therapy.

(Also reference the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” §*220 and* 230, and the Medicare Claims Processing Manual, Chapter 5, “Part B Outpatient Rehabilitation and CORF Services,” §10.1)

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Chapter 1, Part 3 (Sections 170 – 190.34)

Coverage Determinations

(Rev. 55, 05-05-06)

Table of Contents

(Rev. 55, 05-05-06)

170.3 – Speech-*Language* Pathology Services for the Treatment of Dysphagia

(Rev. 55, Issued: 05-05-06, Effective: 10-01-06, Implementation: 10-02-06)

Dysphagia is a swallowing disorder that may be due to various neurological, structural, and cognitive deficits. Dysphagia may be the result of head trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, or encephalopathies. While dysphagia can afflict any age group, it most often appears among the elderly. Speech-*language* pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability. Patients who are motivated, moderately alert, and have some degree of deglutition and swallowing functions are appropriate candidates for dysphagia therapy. Elements of the therapy program can include thermal stimulation to heighten the sensitivity of the swallowing reflex, exercises to improve oral-motor control, training in laryngeal adduction and compensatory swallowing techniques, and positioning and dietary modifications. Design all programs to ensure swallowing safety of the patient during oral feedings and maintain adequate nutrition.

Cross-reference:

The Medicare Benefit Policy, Chapter 15, "Covered Medical and Other Health Services," §§220 and 230.*3*.

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Chapter 1, Part 4 (Sections 200 – 310.1)

Coverage Determinations

290.1 - Home Health Visits to a Blind Diabetic

(Rev. 55, Issued: 05-05-06, Effective: 10-01-06, Implementation: 10-02-06)

Many individuals who are blind and require daily insulin for the control of a diabetic condition are able to administer their injections without assistance (other than possibly that which may be furnished by family members or friends). There are organizations which encourage and train blind diabetics, both to fill their own syringes and to inject themselves. There are also a number of devices available for blind individuals to fill their syringes accurately. However, the individuals who may need assistance with prefilling their syringes may also require periodic observation and evaluation, even though their diabetes is fairly stabilized. In such cases, probably few in number, home health services may be required for this purpose.

To qualify for home health benefits, a blind diabetic must be confined to his home, under the care of a physician, and in need of either skilled nursing services on an intermittent basis or physical therapy or speech-*language pathology services*. Effective July 1, 1981, a person may qualify for home health benefits based on his or her need for skilled nursing services on an intermittent basis, physical therapy, speech-*language pathology*, or occupational therapy. Effective December 1, 1981, occupational therapy is eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical therapy or speech–*language pathology*, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §20.) There must be a plan of treatment, established and periodically reviewed by a physician which indicates that there is a recurring need for home health services to supplement the physician's contacts with the patient; e.g., skilled nursing visits for observing and determining the need for changes in the level and type of care which has been prescribed. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §§30.) Once an initial regimen has been established, the frequency of need for further home health services can vary greatly from patient to patient, depending on their condition and the likelihood of its changing. Some may need visits only every 90 days, for example, while others may require them much more frequently. If a nurse makes a visit to provide skilled services, and also prefills syringes, the purpose of the visit which was to provide skilled services, does not change. However, if the sole purpose of the nurse's visit is to prefill insulin syringes for a blind diabetic, it is not a skilled nursing visit although it may be reimbursed as such as indicated below.

Filling a syringe can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse. Consequently, it would not constitute a skilled nursing service even if it is performed by a nurse. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §30.2.2.) The personal care duties normally performed by home health aides include assisting the patient with medications ordered by a physician which are ordinarily self-administered. (See the Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §50.2.)

Performance of such a service by an aide is consistent with the Medicare conditions of participation for home health agencies. Therefore, home health aide services would be appropriate for those blind diabetics who are qualified for home health benefits and who cannot fill their syringes. An adequately trained home health aide could make intermittent visits, usually on a weekly basis, to the home for the purpose of filling that supply of insulin ordered by the physician.

If State law, however, precludes a home health aide from prefilling insulin syringes, payment may be made for this service as part of the cost of skilled nursing services when performed by a nurse for a blind diabetic who is otherwise unable to prefill his or her syringes. There are no adverse consequences with respect to reimbursement to the home health agency for providing the service in this manner.

If State law does not preclude a home health aide from prefilling insulin syringes, but the home health agency chooses to send a nurse to perform only this task, the visit is reimbursed as if made by a home health aide.

NOTE: As indicated, to qualify for home health benefits, a patient must require skilled nursing services on an intermittent basis or physical therapy or speech-*language pathology*. If a beneficiary does not qualify for home health benefits but only needs someone to prefill syringes with the correct dosage of insulin, then no program payment can be made.

Cross-reference:

The Medicare Benefit Policy Manual, Chapter 7, "Home Health Services," §§20, §§30, §30.2.2 and, §§50.