REGULATIONS AND INSTRUCTIONS FOR PHYSICAL THERAPY SERVICES

1. The Physical Therapist who administers or directly supervises the physical therapy services shall be qualified according to Federal regulations, and shall be currently licensed to practice physical therapy in the State of Maryland.

2. Physical therapy shall be rendered only upon the written order of a licensed Physician, and there shall be re-evaluation of the patient by the Physician at least every thirty days.

3. Physical therapy orders shall be developed in consultation with the Physical Therapist, and sections a. through g. of the orders on the reverse side of this sheet shall be completed if the provider and/or patient is to be reimbursed for the physical therapy services.

4. The Physical Therapist shall make and document an initial evaluation of the patient, and shall make periodic re-evaluations as indicated but at least every thirty days, employing appropriate tests and measurements; and shall enter findings, changes and/or progress on the patient's record at least every two weeks. Tests and measurements of neuromuscular and musculoskeletal function include manual and electrical muscle tests, measurements of joint motion, tests for activities of daily living, gait analysis, postural evaluation, and other tests applicable to physical therapy.

5. Supervision of aides by a licensed, qualified Physical Therapist shall mean direct supervision. The licensed, qualified Physical Therapist shall be immediately available within the treatment area to handle any emergency that may arise during treatment.

6. Physical therapy is reimbursable under the Medicare program only when it is directly related to the active treatment regimen designed by the Physician to restore the patient's level of function which has been lost or reduced by injury or disease.

7. The provider and/or patient shall <u>not</u> be reimbursed for the following:

   a. The use of physical therapy procedures or modalities in a Physician's office by other than a licensed, qualified Physical Therapist or by the Physician himself.

   b. Any treatment for the sole purpose of practicing transfer techniques, walking, or activities of daily living, <u>unless</u> for the purpose of further instruction by the Physical Therapist.

   c. The use of physical therapy procedures or modalities by aides when not under the direct supervision of the licensed, qualified Physical Therapist. For example, if an aide is assigned to walk a patient on the ward or in the patient's home when the Physical Therapist is not present, the treatment shall be considered a part of restorative nursing care and shall not constitute physical therapy services.

PHYSICIAN'S ORDERS FOR PHYSICAL THERAPY

Name of patient: _____ Sex: _____ Age: _____

Diagnosis: _____ Onset: _____

Previous physical therapy related to present illness: From _____ to _____

Date of admission to health facility: _____ Date physical therapy started: _____

The information requested on this page must be filled in if the provider and/or patient is to be reimbursed for physical therapy services.

a. OBJECTIVES OF PHYSICAL THERAPY SERVICES

[ ] Improve function
[ ] Increase strength
[ ] Increase mobility
[ ] Promote healing
[ ] Ambulation
[ ] Self-care
[ ] Relieve pain
[ ] Evaluation

Other: _____

b. TOLERANCE AND CAPACITY OF PATIENT [ ] Low [ ] Fair [ ] Good [ ] Normal

c. PROCEDURES AND MODALITIES	To What Area(s)	DATES OF CHANGES IN PHYSICIAN'S ORDERS	
		Discontinue treatment	Add treatment
[ ] Functional training			
[ ] Testing			
[ ] Heat or cold			
[ ] Therapeutic exercise			
[ ] Electrotherapy			
[ ] Vasopneumatic compression			
[ ] Massage			
[ ] Splinting			
[ ] Ultraviolet			
Other			

d. DURATION AND FREQUENCY OF TREATMENT _____

e. PRECAUTIONS AND/OR ADDITIONAL INSTRUCTIONS _____

f. I certify that the physical therapy services outlined above are necessary to aid in the rehabilitation of this patient. The plan of treatment will be reviewed periodically by me.

Date: _____ _____ M.D.

Recertification

Date: _____ _____ M.D.

Date: _____ _____ M.D.

Date: _____ _____ M.D.

g. I certify that I shall be responsible for administering or directly supervising the physical therapy services ordered by, and in consultation with, the referring Physician. I further certify that I am qualified according to Federal regulations, and that I am currently licensed in the State of Maryland to practice physical therapy.

Original license # _____ Current control # _____

Date: _____ _____ P.T.

(See reverse side for regulations and instructions)

Supplement # 5 a