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Medicare Part B Coding and Billing

For Therapy Services in Long-Term Care

Kathleen D. Weissberg, OTD, OTR/L

Objectives

1. Discuss how clinical documentation creates a clinical picture of the patients condition, justifies reimbursement and functions as a "receipt" for services rendered
2. Identify utilization of and documentation guidelines for commonly billed CPT codes
3. Define factors considered when coding the PT evaluation
4. Define how to accurately apply functional G codes

Objectives

5. Describe how to select appropriate billing codes based on the plan of care
6. Describe how to accurately apply the 8-minute rule
7. Identify coding and billing "red flags" to be observant to when completing audits and completing daily charting
8. Describe the medical review process and strategies for management

Importance of Documentation

- Must support medical necessity
- Paint a picture of the patient's impairments/functional limitations
- Describe skilled therapy
- Justify frequency and duration
- Document treatment minutes
- Identify each specific skilled intervention to justify coding

CPT Coding Guidance

CPT Coding Guidance: Modalities

- Direct (one-on-one) contact means constant attendance
- Modalities are not generally stand-alone treatments
- Multiple heating modalities should not be used on the same day
- As symptoms subside/function improves, discontinue modalities
- Based on descriptors, these apply to one or more areas treated

CPT Coding Guidance: 97010

- CPT 97010 - hot or cold packs (to one or more areas)
 - Bundled code; not separately paid
 - Supportive Documentation
 - The area(s) treated
 - The type of hot or cold application

CPT Coding Guidance: 97012

- Traction, Mechanical (to one or more areas)
 - Generally limited to the cervical or lumbar spine to relieve pain
 - Typically used in conjunction with therapeutic procedures, not as an isolated treatment
 - Equipment and tables utilizing roller systems are not considered true mechanical traction

CPT Coding Guidance: 97012

- Supportive Documentation
 - Type of traction
 - Part of the body to which it is applied
 - Etiology of symptoms requiring treatment

CPT Coding Guidance: 97024

- CPT 97024 – Diathermy
 - Indicated when a large area of deep tissues requires heat
 - Not R&N to perform BOTH thermal US and diathermy to the same region
 - Pulsed wave diathermy is covered for the same conditions as standard diathermy
 - Only 1 unit of CPT code 97024 is covered per date of service

CPT Coding Guidance: 97024

- Supportive Documentation
 - Area(s) being treated
 - Objective clinical findings/measurements to support the need for a deep heat treatment
 - Subjective findings to include pain ratings, pain location, activities which increase or decrease pain, effect on function, etc.

CPT Coding Guidance: 97032

- CPT 97032 – electrical stimulation (manual) (to one or more areas), each 15 minutes
 - Most non-wound care e-stim should be billed as G0283
 - 97032 is a constant attendance code
 - Direct motor point stimulation delivered via a probe
 - Instructing a patient in the use of a home TENS unit

CPT Coding Guidance: 97032

- FES or NMES while performing a therapeutic exercise or functional activity may be billed as 97032
 - Do not bill additional CPT codes for the same time period
- Ultrasound with electrical stimulation provided concurrently is billed as ultrasound (97035)
- If the patient requires supervision for safety, this DOES NOT qualify as constant attendance
- Non-implantable pelvic floor electrical stimulators (e.g., vaginal or anal probes) may be billed as 97032
 - Stimulation delivered via electrodes should be billed as G0283

CPT Coding Guidance: 97032

- Supportive Documentation
 - Type of electrical stimulation used (do not limit the description to “manual” or “attended”)
 - Area(s) being treated
 - If used for muscle weakness, objective rating of strength and functional deficits
 - If used for pain include pain rating, location of pain, effect of pain on function

CPT Coding Guidance: 97033

- CPT 97033 – Iontophoresis (to one or more areas)
 - The evidence from published, peer-reviewed literature is insufficient to conclude that the iontophoretic delivery of NSAIDs is superior to other Tx
 - Not covered by Medicare

CPT Coding Guidance: 97035

- CPT 97035 – Ultrasound (to one or more areas)
 - May be pulsed or continuous width, in conjunction with other procedures, not as an isolated treatment
 - Indications:
 - limited joint motion requiring extensibility
 - symptomatic soft tissue calcification
 - neuromas
 - Phonophoresis is reimbursable by Medicare

CPT Coding Guidance: 97035

- Supportive Documentation
 - Area(s) being treated
 - Frequency and intensity of ultrasound
 - Objective clinical findings such as measurements of range of motion and functional limitations to support the need for ultrasound
 - Subjective findings to include pain ratings, pain location, effect on function

CPT Coding Guidance: G0283

- CPT G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
 - Most non-wound care electrical stimulation treatment provided in therapy should be billed as G0283
 - A supervised modality does not require direct (one-on-one) patient contact by the provider (e.g., IFC, TENS, Russian Stim)
 - Utilized with appropriate therapeutic procedures to effect continued improvement

CPT Coding Guidance: G0283

- Supportive Documentation
 - Type of electrical stimulation used (e.g., TENS, IFC)
 - Area(s) being treated
 - If used for pain include pain rating, location of pain, effect of pain on function

CPT Coding Guidance: Therapeutic Procedures

- Direct (one-on-one) patient contact
- Supervision of a previously taught exercise/program is not covered
- No separate coverage for time spent on documentation

CPT Coding Guidance: 97110

- CPT 97110 - Therapeutic Exercises to develop strength and endurance, range of motion and flexibility (one or more areas, each 15 minutes)
 - Used for restoring strength, endurance, ROM, flexibility where loss/restriction causes functional limitation
 - Active, active-assisted, or passive participation
 - Skills of a therapist to evaluate, design, instruct
 - Repetition after successful teaching and monitoring is non-covered

CPT Coding Guidance: 97110

- Exercises for fitness, flexibility, endurance in absence of a complicated condition are not covered
- Exercises not requiring skilled assessment are not covered
- Documentation must include measurable indicators AND impact on function
- Documentation should describe new exercises added or changes made to justify skill
- Show transition to HEP
- PROM is a short course to include caregiver training

CPT Coding Guidance: 97110

- Supportive Documentation
 - Objective measurements of loss of strength and range of motion (with comparison to the uninvolved side) and effect on function
 - If used for pain include pain rating, location of pain, effect of pain on function
 - Specific exercises performed, purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills of a therapist were required
 - When skilled cardiopulmonary monitoring is required, include documentation of pulse oximetry, heart rate, blood pressure, perceived exertion, etc.

CPT Coding Guidance: 97112

- CPT 97112 - Neuromuscular Re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (one or more areas, each 15 minutes)
 - R&N for:
 - loss of deep tendon reflexes and vibration sense
 - nerve palsy
 - muscular weakness or flaccidity
 - poor static or dynamic sitting/standing balance
 - postural abnormalities
 - loss of gross and fine motor coordination
 - hypo/hypertonicity

CPT Coding Guidance: 97112

- For falls, documentation should indicate:
 - specific fall dates and/or hospitalization(s) and reason for the fall(s), if known
 - most recent prior functional level of mobility
 - cognitive status
 - prior therapy intervention;
 - functional loss due to the recent change in condition
 - balance assessments, LE ROM/MMT
 - patient and caregiver training
 - carry-over of therapy techniques

CPT Coding Guidance: 97112

- Not R&N to extend visits to:
 - remind the patient to ask for assistance
 - offer close supervision of activities due to poor safety awareness
 - remind a patient to slow down
 - offer routine verbal cues for compensatory or adaptive techniques already taught
 - remind a patient to use an assistive device
 - train multiple caregivers

CPT Coding Guidance: 97112

- Supportive Documentation
 - Objective loss of ADL, mobility, balance, coordination deficits, hypo- and hypertonicity, posture, effect on function
 - Specific exercises/activities performed (including progression)
 - Purpose of the exercises related to function
 - Instruction given, and/or assistance needed, to support that the skills of a therapist were required

CPT Coding Guidance: 97113

- CPT 97113 - Aquatic Therapy with Therapeutic Exercises (one or more areas, each 15 minutes)
 - Any activity/exercise performed in water
 - R&N for ROM, strength, mobility, balance; persons who cannot tolerate land therapy
 - Exercises become repetitive quickly
 - Transition to land-based exercise ASAP
 - Only count skilled minutes; do not count time to dress/undress, get into and out of the pool, etc.

CPT Coding Guidance: 97113

- Supportive Documentation
 - Justification for use of a water environment
 - Objective loss of ADLs, mobility, ROM, strength, balance, coordination, posture and effect on function
 - If used for pain include pain rating, location of pain, effect of pain on function
 - Specific exercises/activities performed (including progression of the activity), purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills and of a therapist were required

CPT Coding Guidance: 97116

- CPT 97116 - Gait Training (includes stair climbing) (one or more areas, each 15 minutes)
 - Indications include, but are not limited to:
 - a CVA/musculoskeletal trauma requiring ambulation reeducation
 - progressively debilitating condition for which safe ambulation has recently become a concern
 - a condition that requires instruction in the use of a walker/cane
 - retraining in stairs/steps or other uneven surfaces appropriate to home and community function
 - instructing a caregiver in appropriate guarding and assistive techniques
 - Repetitive walk-strengthening exercise to increase endurance or distance is not covered

CPT Coding Guidance: 97116

- Supportive Documentation
 - Objective measurements of balance and gait distance, assistive device used, amount of assistance required, gait deviations and limitations being addressed, use of orthotic or prosthesis, need for and description of verbal cueing
 - Presence of complicating factors (pain, balance deficits, gait deficits, stairs, architectural or safety concerns)
 - Specific gait training techniques used, instructions given, and/or assistance needed, and the patient's response to the intervention, to demonstrate that the skills of a therapist were required

CPT Coding Guidance: 97124

- CPT 97124 – Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) (one or more areas, each 15 minutes)
 - Adjunctive treatment to another therapeutic procedure
 - Massage chairs, etc. are non-covered
 - Not covered as an isolated treatment
 - Not covered the same day as 97140
 - Do not bill 97124 for percussion for postural drainage

CPT Coding Guidance: 97124

- Supportive Documentation
 - Area(s) being treated
 - Objective clinical findings such as measurements of range of motion, description of muscle spasms and effect on function
 - Subjective findings including pain ratings, pain location, effect on function

CPT Coding Guidance: 97140

- CPT 97140 - Manual Therapy Techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
 - Joint mobilization (peripheral and/or spinal)
 - Myofascial release/soft tissue mobilization
 - Manipulation
 - Manual lymphatic drainage/complex decongestive therapy (MLD/CDT)

CPT Coding Guidance: 97140

- Manual lymphatic drainage/complex decongestive therapy (MLD/CDT)
 - Primary and secondary lymphedema
 - Coverage if these conditions are met:
 - physician-documented diagnosis of lymphedema (primary or secondary)
 - documented signs or symptoms of lymphedema
 - the patient or patient caregiver has the ability to understand and comply with the continuation of the treatment regimen at home

CPT Coding Guidance: 97140

- Supportive Documentation
 - Area(s) being treated
 - Soft tissue or joint mobilization technique used
 - Objective and subjective measurements of areas treated and effect on function
 - For MLD/CDP:
 - medical history, comorbidities, prior treatment
 - cognitive and physical ability for carryover
 - limitation of function/PLOF
 - limb measurements and description of skin

CPT Coding Guidance: 97530

- CPT 97530 - Therapeutic Activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
 - Movement activities can be for a specific body part or could involve the entire body.
 - Involves functional activities to restore functional performance in a progressive manner
 - Directed at a loss or restriction of mobility, strength, balance, or coordination
 - Directed at a specific outcome

CPT Coding Guidance: 97530

- In order to be covered:
 - documented condition for which TA can be expected to restore function
 - clear correlation between type of TA and underlying medical condition
 - condition is such that he/she is unable to perform the therapeutic activities without skilled intervention

CPT Coding Guidance: 97530

- Supportive Documentation
 - Objective measurements of loss of ADLs, balance, strength, coordination, range of motion, mobility and effect on function
 - Specific activities performed, and amount and type of assistance to demonstrate that the skills and expertise of the therapist were required

CPT Coding Guidance: 97542

- CPT 97542 - Wheelchair Management (e.g., assessment, fitting, training), each 15 minutes
 - Assessment for non-specialized wheelchairs, cushions, lapboards, etc. w/o complicating condition is not skilled
 - If pt. can self-correct, not skilled
 - Care turned over to caregivers ASAP
 - Ongoing visits for increasing sitting times not R&N
 - Visits for restraint reduction are generally non-covered
 - Expected that multiple seating deficits discovered during the initial evaluation would be treated concurrently

CPT Coding Guidance: 97542

- Supportive Documentation
 - Describe the interventions to show that the skills of a therapist were required. For example, describe the various wheelchair adaptations trialed and the patient's response to the intervention. If training is provided, describe the type of training, the amount of assistance required and the patient response to the training.

CPT Coding Guidance: 97760

- CPT 97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
 - Not reported with 97116 for the same extremity
 - May be prefabricated or custom-fabricated.
 - For uncomplicated conditions, these are not R&N
 - Issuing off-the-shelf splints for foot drop or wrist drop
 - Issuing off-the-shelf foot or elbow cradles for routine pressure relief
 - Issuing "carrots" or towel rolls for hand contractures
 - Bed positioning (e.g., pillows, wedges) to relieve potential pressure

CPT Coding Guidance: 97760

- Repetitive range of motion prior to placing an orthotic/positioner to maintain the range of motion is not reasonable and necessary
- Ongoing therapy visits for increasing wearing time are generally not reasonable and necessary
- Ongoing visits are billed with CPT 97763

CPT Coding Guidance: 97760

- Supportive Documentation
 - A description of the patient's condition (including applicable impairments and functional limitations) that necessitates an orthotic
 - Any complicating factors
 - The specific orthotic provided and the date issued
 - A description of the skilled training provided
 - Response of the patient to the orthotic

CPT Coding Guidance: 97761

- CPT 97761 - Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
- Includes preparation of the stump, skin care, modification of prosthetic fit, initial mobility
 - Gait training with the prosthesis coded with 97116
 - Supportive Documentation
 - Type of prosthesis, extremity involved
 - Specific training provided and amount of assistance needed
 - Any complicating factors and specific description of these (with objective measurements), such as pain, joint restrictions/contractures, strength deficits, etc.

CPT Coding Guidance: 97763

- CPT 97763 - Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
 - Established patients who have already received their orthotic or prosthetic device.
 - Supportive Documentation
 - Reason for assessment
 - Findings from the assessment
 - Specific device, modifications made, instruction given

Plan of Care

Knowing where we are (current function) and where we want to go (patient-centered, functional goals)...

- What path will we travel (CPT selection)?
- How long will it take (frequency/duration)?

Let's Practice

- "Pt to transfer sit<>stand from bed, w/c and dining room chair w/ SBA using UEs for push-off and ≤ 3 VCs to bring COG over BOS"
- Which CPT code should I select?
 - 97530, Therapeutic activities
- Why?
 - AMA Description: Therapeutic activities, direct (one-on-one) contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

continued™

Let's Practice

- “↑ R shoulder flex/abd to 160 deg to be able to wash hair (l)”
- Which CPT code should I select?
 - 97110, Therapeutic exercises
- Why?
 - AMA description: Therapeutic procedure, one or more areas, each 15 min; therapeutic exercises to develop strength, endurance, range of motion and flexibility

continued™

Let's Practice

- “Pt will demonstrate appropriate execution of protective extension reactions in sitting 4/5 trials to be able to effectively protect from a fall”
- Which CPT code should I select?
 - 97112, Neuromuscular reeducation
- Why?
 - AMA description: Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities

continued™

Let's Practice

- “Inhibited tone through rotation in R lateral trunk to improve wheelchair positioning”
- What should we bill?
 - 97112, neuromuscular re-ed

Why?

continued™

Let's Practice

- “Improved wheelchair positioning obtained by strengthening core to obtain anterior pelvic tilt”
- What should we bill?
 - 97110, ther ex

Why?

continued™

Let's Practice

- "Utilized right lateral bolster in wheelchair to improve midline alignment"
- What should we bill?
 - 97542, wheelchair management

Why?

continued™

Physical Therapy Evaluation Codes

Evaluation Codes for PT

- Evaluation
 - 97161 Low Complexity Evaluation
 - 97162 Moderate Complexity Evaluation
 - 97163 High Complexity Evaluation
- Re-evaluation
 - 97164

Elements of an Evaluation

- Examination
- Evaluation
- Diagnosis
- Prognosis
- Plan of Care

Evaluation Codes for PT

- Stratify the patient population
- Move beyond diagnosis stratification
- Acknowledge that patients vary due to comorbidities and other personal factors
- Places value on the clinical decision making required to provide medically necessary care

Components of the Evaluation Code

- History
 - Medical and functional, including relevant comorbidities and personal factors
- Examination
- Clinical presentation
- Clinical decision making
 - The use of a standardized patient assessment instrument and/or measurable assessment of functional outcome

Closer Look: History

- Comorbidities that impact function and ability to progress through a plan of care
- Previous functional level; context of current functional abilities
- Treatment approaches in past if applicable and other factors that may impact patients ability to progress and reach goals
- Includes social history, living environment, work status, cultural preferences, medications, other clinical tests, and more

Closer Look: Examination

- Includes any of the following:
 - Body structure and functions
 - Impairments (ROM, strength, balance deficits)
 - Activity limitations
 - Difficulty executing tasks or actions
 - Participation restrictions

Closer Look: Clinical Presentation

- Stable and uncomplicated OR
- Evolving clinical presentation with changing clinical characteristics OR
- Evolving clinical presentation with unstable and unpredictable characteristics

Closer Look: Clinical Decision Making

- Based on the composite of the patient's presentation ("the dynamic interaction between the health condition and the contextual factors"- ICF)
- This clinical judgement occurs at each encounter or session informed as much as possible by current best evidence

97161 Low Complexity

HISTORY	EXAMINATION	PRESENTATION	DECISION MAKING
No personal factors and/or comorbidities that impact the plan of care	Examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions	Stable and/or uncomplicated characteristics	Low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome

Source: (FR 2016 Table 19, p 350)

97162 Moderate Complexity

HISTORY	EXAMINATION	PRESENTATION	DECISION MAKING
1-2 personal factors and/or comorbidities that impact the plan of care	Examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following body structures and functions, activity limitations, and/or participation restrictions	Evolving clinical presentation with changing characteristics	Moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome

Source: (FR 2016 Table 19, p 350)

97163 High Complexity

HISTORY	EXAMINATION	PRESENTATION	DECISION MAKING
3 or more personal factors and/or comorbidities that impact the plan	Examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions	Clinical presentation with unstable and unpredictable characteristics	High complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome

Source: (FR 2016 Table 19, p 350)

Consider the Following ...

- Do not bill for a therapy initial evaluation on more than one date of service
- Do not bill test and measurement, ROM, or MMT codes on the same day as the initial evaluation
- Do not bill therapy screenings utilizing the evaluation codes. Screenings are not billable services.
- If prior functional abilities will spontaneously return, evaluation is not medically necessary

Consider the Following ...

- Pre-operative evaluations performed routinely to ascertain the patient's post-surgical needs or to explain services are non-covered
- If treatment is given on the same day as the initial evaluation, the treatment is billed using the appropriate CPT codes
- Generalized aging, weakness or debility do not qualify as Medicare covered conditions for assessment or therapy services

97164 Physical Therapy Re-evaluation

- A single level code
- Applies when there is an established and ongoing plan of care
- Requires an examination including a review of history AND the use of standardized tests and measures
- Describes a REVISED plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome

Consider the Following ...

- Indications for a reevaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care
- Documentation **MUST** support the re-evaluation code
- Re-evaluation may be indicated
 - Following hospitalization during the therapy interval if there has been a significant change in function
 - At a planned discharge with supportive documentation

Consider the Following ...

- Re-evaluations should contain all the applicable components of an initial evaluation and must be completed by a clinician
- Not a routine, recurring service
 - Do not bill re-eval to update POC, progress report, etc.
- Re-evaluation codes are untimed, billable as one unit

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Patient Case #1

- 81 y/o Male with a 3 yr. history of intermittent LBP, increasing in frequency to daily over the past 2 mo. BMI 33, no other co-morbidities; Fluctuating pain from 3-9/10; now 7/10. Ostwestry 35; Ability to walk from room to dining room is interrupted at least 1x/wk. due to LBP; Unable to stand more than 5 min; Sleep varies but is impacted 3/5 nights.

continued™

Patient Case #1

HISTORY	EXAMINATION	PRESENTATION	DECISION MAKING
BMI Frequency/ Chronicity	Ability to ambulate to meals Standing Sleep	Evolving/ Changing Pain	Moderate Ostwestry 35

- Answer: 97162 Moderate Complexity

Patient Case #2

- 85 y/o male with 6 month history of pain and stiffness of his right shoulder. Using NSAIDS and is self-limiting activity. History of poorly controlled diabetes; reports dropping objects often, difficulty dressing and other self care activities, and inability to assist in household activities all due to the pain. Shoulder ROM limited in a capsular pattern. Low UEFS score.

Patient Case #2

HISTORY	EXAMINATION	PRESENTATION	DECISION MAKING
Acuity/ chronicity Diabetes status	Carrying/ handling Self care Household tasks Upper Extremity	Unstable and unpredictable blood sugars	UEFS

- Answer: 97162 Moderate Complexity

Patient Case #3

- 86 year old female 7 weeks post THA (in SNF 4 weeks, 3 weeks of home health) post operative infection resolving (was on IV antibiotics), mild dementia with some short term memory loss, ambulates with wheeled walker. TUG 25 sec Berg 40 (fall risk). She is dependent on spouse for meal preparation and bathing. PROM 15-80 degrees. 10 degree extensor lag. Knee Outcome Survey 30, pain 3/10 but 7/10 with ROM exercise. Prior to surgery she was independent in community ambulation.

Patient Case #3

HISTORY	EXAMINATION	PRESENTATION	DECISION MAKING
THA Post operative infection Dementia	Meal prep Bathing Balance Lower extremity	Pain, infection & cognition unstable and unpredictable characteristics	TUG BERG Knee Outcome Survey

- Answer: 97163 High Complexity

continued™

Patient Case #4

- 72 y/o female 4 days post knee sprain during Zumba class; no prior injuries; no co-morbidities; Pain is 4/10 (decreased from 8/10 at onset); LEFS score 45; moderate swelling of the knee; limited ROM; moderately impaired balance; no deficits with the trunk, hip or ankle.

continued™

Patient Case #4

HISTORY	EXAMINATION	PRESENTATION	DECISION MAKING
No relevant comorbidities or personal factors	LE (Knee, hip and ankle) Trunk	Stable and predictable	LEFS

- Answer: 97161 Low Complexity

continued™

ICD-10 and Other Coding Topics

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Benefits of ICD-10

- Improved specificity
- Availability to add new codes
- Use of full code titles
- Expands on combination codes

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ICD-10 Code Structure

- Characters 1-3: Category
- Characters 4-6: Etiology, anatomic site, severity or other clinical detail
- Character 7: Extension

continued™

For Example

S52 Fracture of forearm

S52.5 Fracture of lower end of radius

S52.52 Torus fracture of lower end of radius

S52.521 Torus fracture of lower end of right
radius

S52.521A Torus fracture of lower end of right
radius, initial encounter for closed fracture

Medical vs. Treatment Diagnosis

- Primary (Medical) diagnosis must be a pertinent, documented, medical condition
- Primary (Medical) diagnosis is the disease, illness, condition or injury the patient has suffered
- Treatment diagnosis is the reason/problem for which therapy services are rendered
- Treatment diagnosis is caused by the Primary diagnosis in most instances

Modes of Therapy Individual Therapy

- The treatment of one resident at a time
- The resident receives the therapist's full attention
- Treatment individually at intermittent times during the day is individual treatment and is added for the daily count

continued™

Modes of Therapy

Concurrent Therapy

- No concurrent therapy for Medicare Part B
- The treatment of two or more residents at the same time is documented as group treatment

continued™

Modes of Therapy

Group Therapy

- Therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities
 - For example, therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time

For Example

- In a 25-minute period, a therapist works with two patients, A and B, and divides his/her time between the two patients
 - The appropriate coding 1 97150 for each patient
- Supportive Documentation
 - The purpose of the group and the number of participants in the group
 - Description of the skilled activity provided in the group setting

Therapy Students Medicare Part B

The following criteria must be met in order for services to be billed. The qualified professional is:

- Present and in the room for the entire session
- Directing the service, making the skilled judgment and is responsible for the assessment and treatment
- Not engaged in treating another patient or doing other tasks at the same time
- Responsible for the services and signs all documentation
 - Student may also sign, but this is not required
- PTAs/COTAs can serve as clinical instructors under their scope of practice and supervision of a PT/OTR

Utilization Guidelines for CPT Coding

Utilization Guidelines: CPT

- Untimed CPT Codes
 - Not defined in the AMA CPT Manual by a specific time frame (such as “each 15 minutes”)
 - Based on the number of times the procedure is performed, often once per day
- Timed CPT Codes
 - Direct (one-on-one) time
 - Generally 15 minute increments

CPT Coding: “8 Minute Rule”

- Applies to CPT codes timed in 15-min increments only
- For any single CPT code, bill appropriate number of units based on specified time intervals
- If more than one 15-min timed code is billed on a calendar day, the total number of units that can be billed is constrained by the total treatment time

“8 Minute Rule”

- 1 unit > 8 minutes through 22 minutes
- 2 units > 23 minutes through 37 minutes
- 3 units > 38 minutes through 52 minutes
- 4 units > 53 minutes through 67 minutes
- 5 units > 68 minutes through 82 minutes
- 6 units > 83 minutes through 97 minutes
- 7 units > 98 minutes through 112 minutes
- 8 units > 113 minutes through 127 minutes

Documenting Treatment Time

- Do not record as “Time in/Time out”
- Do not “round” minutes; record the actual treatment time
- Do not record “units” of treatment, instead of minutes
- Do not include unbillable time (e.g., changing, waiting, resting, toileting)

For Example

20 minutes therapeutic exercise (97110)

15 minutes therapeutic activities (97530)

20 minutes unattended electrical stimulation (G0283)

Timed Code Treatment Minutes: 35 minutes

Total Treatment Time: 55 minutes

For Example

- 20 minutes of Therapeutic Exercise (CPT 97110) = one 15-minute block + 5 remaining minutes
 - At least 1 unit must be allocated to this code
- 38 minutes of Therapeutic Activities (97530) = two 15-minute blocks + 8 remaining minutes
 - At least 2 units must be allocated to this code
 - If 38 minutes of CPT 97530 is the only treatment provided, then 3 units would be billed

Let's Practice

- Pt s/p hip fracture
 - 24 minutes of balance strategy retraining
 - 23 minutes of LE exercises for strength
- What should we bill?
 - 2 units 97112, neuromuscular re-ed
 - 1 unit 97110, ther ex

continued™

Let's Practice

- Pt s/p hip fracture
 - 20 minutes of balance strategy retraining
 - 20 minutes of LE exercises for strength
- What should we bill?
 - 2 units 97112 + 1 unit 97110 – OR –
 - 1 unit 97112 + 2 units 97110

continued™

Let's Practice

- Pt s/p rotator cuff repair
 - 4 minutes assessing shoulder strength prior to initiating and progressing therapeutic exercise
 - 32 minutes ROM instruction
 - 7 minutes of joint mobilization
- What should we bill?
 - 2 units 97110, ther ex
 - 1 unit 97140, manual therapy

Let's Practice

- Pt c/o low back pain
 - 18 minutes of exercises
 - 13 minutes of myofascial release techniques
 - 10 minutes of gait on stairs
 - 8 minutes of ultrasound for pain
- What should we bill?
 - 1 unit 97110, ther ex
 - 1 unit 97140, manual therapy
 - 1 unit 97116, gait training

Let's Practice

- Pt with dementia
 - 7 minutes of balance strategies for falls
 - 7 minutes LE ROM
 - 7 minutes transfer and bed mobility training
- What should we bill?
 - 1 unit 97112 (neuro, re-ed) – OR – 1 unit 97110 (ther ex) – OR -- 1 unit 97530 (ther act)

Let's Practice

- New patient admitted to program
 - 35 minutes PT evaluation
 - 25 minutes exercise/ROM
 - 8 minutes bed mobility
- What should we bill?
 - 1 unit 97161 (PT eval)
 - 2 units 97110 (ther ex)

Let's Practice

- New patient admitted to program
 - 40 minutes PT evaluation
 - 20 minutes e-stim IFC for pain
 - 10 minutes exercise
- What should we bill?
 - 1 unit 97163 (PT eval)
 - 1 unit G0283 (unattended e-stim)
 - 1 unit 97110 (ther ex)

continued™

Keep in Mind ...

- Miscoded services may lead to denial
- Do not bill for documentation time separately
- Do not code higher than what the procedure requires
- Do not select the code based on reimbursement
- Do not “unbundle” services/procedures
- Do not bill separately for supplies
- Co-treatment is not permitted for Part B

continued™

Therapy Documentation

Only those modalities/procedures that can be
verified in the medical record as rendered
can be considered for payment

Treatment Notes

- Required for every treatment day/service to justify codes/units on the claim
 - Must include:
 - date of treatment
 - identification of each specific treatment, intervention or activity provided in language that can be compared with the CPT codes to verify correct coding
 - record of the total time spent in services represented by timed codes under timed code treatment minutes
 - record of the total treatment time in minutes, which is a sum of the timed and untimed services
 - signature and credentials of each individual(s) that provided skilled interventions

CCI Edits and G Coding

National Correct Coding Initiative (NCCI)

- NCCI edits implemented to provide additional guidance billing
- Edits may be bypassed if the required modifier is present on the claim **and** documentation supports the use of the modifier and the medical necessity of treatment
 - Modifier -59 indicates distinct procedural service
 - Modifier -KX indicates services over the Part B Cap

CCI Edit Example

- Billing record:
 - 2 units 97530, ther act
 - 1 unit 97116-59, gait training
- Documentation to support modifier -59:
 - Transfer training bed to wheelchair w/ facilitation of weight shift over involved LE, focus on eccentric control of quads during sit to stand **followed by** gait training 150 feet with wheeled walker focusing on active dorsiflexion for heel strike and equal stride length

Part B Cap Exception

- For beneficiary to qualify for exception, essential therapists clearly document the:
 - Medical necessity/need for services
 - Condition and complexities justifying exception
 - Skilled service provision to support medical necessity
- Nursing documentation must support therapy
- Modifier –KX indicates services over the Part B Cap

MCTRJCA of 2012

- The Middle Class Tax Relief and Job Creation Act of 2012 requires CMS to implement:
 - “...a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services...Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.”



G-Codes and Severity Modifier Reporting

- Claims for therapy services furnished on or after July 1, 2013, that do not contain the required functional G-code/modifier information will be rejected



G-Codes and Severity Modifier Reporting

- Applies to **ALL** Medicare Part B therapy claims
 - Below the cap **and** above the cap
- Applies to **ALL** therapy settings
- Non-payable G-codes with severity modifiers are submitted with billing claim
 - Correlate to current and projected functional status
- CMS is gathering data therapy outcomes

Reporting Requirements

- Therapists will report on **only ONE** functional limitation at the beginning of therapy
 - If therapy continues after this treatment goal is achieved/functional limitation is resolved, the therapist will select a different limitation to report
- This does **NOT** mean the therapist must treat only one condition/functional limitation at a time
- This does not limit multiple disciplines reporting on the same limitation at the same time

Reporting Requirements

- The G-code chosen should be:
 - The most appropriate as determined by the therapist; **AND**
 - Most closely relate to the most clinically relevant functional limitation at the time of the initial therapy evaluation & establishment of the POC; **AND/OR**
 - Be one that would yield the quickest &/or greatest change; **AND/OR**
 - Be the one that is the greatest priority for the patient.

What is a Functional Limitation

- Activity limitation
 - A difficulty encountered by an individual in executing a task or action
- Participation restriction
 - A problem experienced by an individual in involvement in life situations

G-codes

- 42 Functional G-codes, 14 sets of 3 codes each
 - 6 sets typically reported for PT & OT
 - 8 sets typically reported for SLP
- Each G-code set contains 3 codes to represent:
 - Current status
 - Projected goal status (LTG)
 - Discharge status

PT & OT G-Codes

Code	Descriptor
Mobility: Walking & Moving Around G8978, G8979, G8980	<ul style="list-style-type: none"> • Short & long distances; different surfaces; around obstacles • Climbing, crawling, running, jumping, swimming • Moving around in home, outside home/building • Using equipment (wheelchair), using transportation
Changing & Maintaining Body Position G8981, G8982, G8983	<ul style="list-style-type: none"> • Changing/maintaining a basic body position: bed mobility, lying down, squatting, kneeling, sitting, standing, bending, shifting center of gravity, other • Transferring oneself: while sitting, while lying, other

PT & OT G-Codes

Code	Descriptor
Carrying, Moving & Handling Objects G8984, G8985, G8986	<ul style="list-style-type: none"> • Lifting & carrying objects: in hands, arms, with shoulder, hip, back, on head, putting objects down (home management-cooking, cleaning) • Moving objects with LEs: pushing, kicking • Hand & arm use: picking up, grasping, manipulating, releasing, fine hand use, throwing, reaching, push, pull, catching
Self Care G8987, G8988, G8989	<ul style="list-style-type: none"> • Washing/drying oneself, caring for body parts (skin, teeth, hair, nails), toileting • Dressing (choosing appropriate clothing, donning/doffing, footwear), eating, drinking • Looking after one's health

PT & OT G-Codes

Code	Descriptor
Primary Other G8990, G8991, G8992	<ul style="list-style-type: none"> Other physical or occupational therapy functional limitation (wound care, continence improvement, contracture management, etc.)
Subsequent Other G8993, G8994, G8995	<ul style="list-style-type: none"> Other physical or occupational therapy functional limitation Only use as a 2nd code after primary "other"

Severity Modifiers

- Once the G-code is chosen, a corresponding severity modifier is used to indicate the level of impairment
- CMS recommends using a standardized assessment/outcomes measure to determine severity index and corresponding modifier
- Documentation must support G code and intensity modifier

Severity Modifiers

Modifier	Impairment Limitation Restriction
CH	0% impaired, limited or restricted
CI	At least 1% but <20% impaired, limited, restricted
CJ	At least 20% but <40% impaired, limited, restricted
CK	At least 40% but <60% impaired, limited, restricted
CL	At least 60% but <80% impaired, limited, restricted
CM	At least 80% but <100% impaired, limited, restricted
CN	100% impaired, limited or restricted

Severity Modifiers

- Therapist must document in the medical record how they made the modifier selection so the same process can be followed at successive assessment intervals
- Use the “CH” modifier (0% impairment) when the therapy services provided are not intended to treat a functional limitation (e.g., wound care)

Severity Modifiers

- In cases where the beneficiary's improvement is expected to be limited or when the therapist does not expect improvement (e.g., maintenance to prevent decline), the same modifier may be used for current status and projected goal status

Reporting Requirements

- G-codes are “Always Therapy” codes
 - Require a therapy modifier to indicate discipline
 - GP – under a PT POC
 - GO – under an OT POC
 - GN – under an SLP POC
- G-codes must be reported along with a “regular” billable therapy service

Documentation Requirements

- The clinician documents, on the applicable dates of service, the specific non-payable G-codes & severity modifiers reported on the claim, including how the selection was made—such as, where the therapist:
 - Uses clinical judgment to determine the modifier
 - Uses a standardized assessment
 - Uses a functional assessment tool

Documentation Requirements

- Per CMS, “The beneficiary functional limitation(s) reported on claims, as part of the functional reporting, must be consistent with the functional limitations identified as part of the therapy plan of care for each discipline and expressed as part of the beneficiary’s anticipated long-term goals”

Reporting Requirements

- Two G-codes are reported each time
 - Current/discharge status
 - Goal status
- Documentation must be completed by the clinician furnishing the service
 - Therapist assistants cannot determine G-codes and modifiers

Reporting Requirements

- Initial evaluation
- 10th visit Progress Report
- Evaluative procedure/re-evaluation
- Discharge
- If reporting ends on a limitation and therapy will continue
- When reporting is begun on a different limitation in the same episode of care

Where should this be documented?

- At the outset of therapy (i.e., SOC)
 - Document in the evaluation, POC or treatment note
- At the end of each progress reporting period
 - Document in the progress report or treatment note
- When a re-evaluation is necessary & billed
 - Document in the re-eval or treatment note

Where should this be documented?

- At discharge from therapy or to end reporting on one functional limitation before reporting on another is begun
 - Document in DC note/summary or treatment note
 - Document in the progress report related to the end of that functional limitation

Where should this be documented?

- On the first treatment day after the progress report that ended the previous functional limitation
 - Document in the treatment note that begins the reporting period for the new limitation- **or**-
 - Per CMS discussions, if the therapist ends one impairment on Tuesday during their treatment/note then they can establish the next impairment on the same day. However because you can't report 2 G codes on the same day, the new impairment would be applied on the billing that occurs at the next visit regardless of who(therapist or assistant) actually provides the next visit."

Medical Review

continued™

“Can I see a receipt?”

Would you pay a mechanic \$1000 for car repairs if he didn't have an itemized receipt to support his charges?

continued™

Affordable Care Act Provisions

- New resources to fight fraud
 - \$350 million over 10 years
 - Health Care Fraud and Abuse Control
- Expanded overpayment recovery efforts
 - Failure to return overpayments
 - RAC expansion

Medical Review

- Medical Review Process
 - A healthcare investigator reviews the documents submitted to determine whether the services are covered
 - Has all the requested documentation been sent?
 - Is there a timely and complete certification/re-certification for this claim period?
 - Is the Plan of Treatment current and complete for all the treatments rendered?

Medical Review

- Medical Review Process
 - Does the therapy meet Medicare guidelines?
 - Is the treatment reasonable (intensity/frequency/duration and necessary diagnosis codes)?
 - Does the treatment require the skill of a qualified therapist?
 - Is the patient making significant progress?
 - Are the services and number of units billed on the claim reflected in the medical record?

Medical Review

- Who are the agencies?
- What are they auditing?
- How do we manage the medical review process?
- How can we prepare?

Reviewing Body	Type of Claims	Selection Process	Volume of Claims	Purpose of Review
MAC	All	Targeted	Dependent on # of claims with improper payments	Prevent future improper payments
CERT	All	Random	Small (120,000)	Measure improper payments
RAC	All	Targeted	Dependent on # of claims with improper payment	Detect & correct past improper payments
ZPIC	All	Targeted	Dependent on # of potential fraud claims	Identify potential fraud
OIG	All	Targeted	Dependent on # of potential fraud claims	Identify fraud

Types of Review

- Probe review
 - Provider-specific
 - Widespread probe
- Pre-pay review
- Post-pay review
- Targeted medical review (TMR)

Managing the Review Process

- Know state practice acts/survey guidelines
- Identify MAC; review LCDs and NCDs
- MAC diagnosis to treatment edits
- Timely response to all requests (30 days for ADR)
- Documentation **must** support services billed

Why are Claims Denied?

- Medical necessity
- Services over the cap not justified
- CPT codes do not reflect services provided
- Unit to minute conversion
- Therapy does not follow LCD
- Nursing documentation does not support therapy

Why are Claims Denied?

- Re-evaluation
- Services not reasonable and necessary
- Transition to HEP
- Excessive therapy services
- Unskilled services
- Documentation is missing
- Lack of physician approval

Why are Claims Denied?

- Failure to return medical records within the 30 day limit
- Records were for wrong dates of service
- Records were for wrong service/modality
- Duplication of services
- Information required to make payment was missing
 - Modality minutes
 - Initial evaluation
 - Documentation does not support billing

Why are Claims Denied

- Information required to make payment was missing
 - Modalities billed not indicated in POC
 - More than one unit is billed for an untimed CPT code
 - Treatments do not correspond to CPT definition
 - Dates billed are not the dates charted
 - Patient's name not on every page

Examples of Non-Covered Services

- Expected restoration potential is insignificant in relation to the extent and duration of therapy
- General range of motion to maintain function
- Activities to provide diversion or general motivation
- A home exercise program taught at the end of the skilled program

What Can You Do?

- Perform Medicare documentation and billing audits
 - Audit high Part B dollars/over the cap
- Ensure all billing/coding meets LCD guidelines
- Technical components (e.g., CCI edits, KX, G Codes)
- Ensure all documentation supports services billed – Tell the story
- Develop a system to verify all aspects of technical Medicare requirements and support data
- Administration to have a strong participation in Medicare & Medicaid practice oversight

continued^{ed}

Thank You

Dr. Kathleen Weissberg, OTD, OTR/L
redhead_lxx@yahoo.com