



Outpatient Therapy Guidelines Mediasite Script

Topics addressed in this article include:

- Policies and Coverage
 - PHYSMED-001
 - PHYSMED-009
 - Centers for Medicare & Medicaid Services (CMS) Internet-only Manuals (IOM)
- Coding Resources
- Documentation
- Top Billing Errors

PHYSMED-001 indicates outpatient therapy should be performed under the care of a physician or non-physician practitioner (NPP). A physician order is no longer required for outpatient physical therapy care. The order indicates the physician is involved in the therapy service. If you are still requiring an order, keep a copy on file. The order is not the basis for payment; certification and recertification are the basis for payment.

A physician, NPP, or the therapist providing the service must develop a plan of care before treatment begins. If the physician or NPP develops the plan of care, a consultation with the treating therapist is recommended. If the therapist develops the plan of care, treatment can occur on the same day. Most likely this occurs during the initial visit; the therapist evaluates the patient, establishes the plan of care, and treats the patient during this visit.

When establishing the plan of care, the findings from the evaluation should be considered and consistent to the contents of the plan of care. The plan of care must indicate:

- The patient's diagnoses
- The long-term treatment goals for the entire episode (Not just for one 30 day interval of care)
- Type of therapy (i.e. physical therapy (PT), occupational therapy (OT), or speech language therapy (SLT))
 - Each type of therapy must have a different plan of care
- Amount – number of times in a day the treatment is provided
 - No specification Medicare will assume one time per day
- Frequency – number of times in a week
 - No specification Medicare will assume one time per week
- Duration – Number of weeks or number of treatment sessions for this plan of care

Changes to the plan of care must be in writing and requires a signature of the physician, NPP, or therapist in charge of the patient's care.

Medicare expects that you obtain a certification (an approval of the plan of care) "As soon as possible" which means before the end of the first interval. The plan of care must be reviewed, dated, and signed by a physician/NPP every 30 days to complete the certification requirements. Medicare no longer requires physician visits for recertification.

Delayed certifications are acceptable without justification for up to 30 days after they are due. Any necessary evidence to justify the delay should be maintained in the patient record. It is not intended that therapy be discontinued when the certification is delayed. Medicare will not deny payment unless we believe that a physician/NPP is not involved in the patient's care. Denials can be overturned at a later date with appropriate documentation.



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Physical Therapy Assistants (PTA) and Occupational Therapy Assistants (OTA) must be supervised by a therapist, not a physician. Direct supervision¹ is required in private practice; all other locations require general supervision².

Medicare does not cover therapy services when performed by the following:

- Message therapist
- Athletic Trainers
- Kinesiotherapists
- Low Vision Specialist
- Any other profession not trained in therapy services

If the therapist chooses to bill under a physician, incident-to guidelines, direct supervision is required.

The chart beginning on page 28 of PHYSMED-001³ contains a variety of symbols and indicators help you avoid denials. It is important to know the underlined codes are considered always therapy services, regardless of who performs them, and will always require a modifier.

PHYSMED-009 contains more specific coverage guidelines for modalities and therapy procedures.

Generally speaking, the plan of care should not include only modalities. The use of therapeutic exercise has proven to be an important part of a therapy program. Therefore, it is expected that a treatment plan consists not solely of modalities but includes therapeutic procedures. Exceptions do occur, such as wound care.

The correct coding initiative (CCI) edits identify certain modalities as components of other modalities and procedures that are not reimbursed separately... You should check CCI edits when you are billing multiple modalities for those procedures considered as bundled. The CCI edits are located at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

Hot or cold pack therapy (procedure 97010) is a status "B" code on the Medicare Physician Fee Schedule Database (MPFSDB). Hot or cold packs provided on the same day of therapy are considered bundled and not separately payable.

Electrical stimulation therapy (E-Stem), procedure code G0283, unattended may be covered for one or two office treatments to determine the effectiveness for patient education for home use. Home use is covered by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). E-Stem coverage information is published in policy PHYSMED-009.

Iontophoresis (Ionto), procedure code 97033, documentation must support its use including:

- Dosage of prescribed medication
- Amount
- Frequency
- Duration of treatment

Topical medications for Ionto are not covered. Policy PHYSMED-009 does not contain a list of a covered diagnosis for Ionto (97033); this does not mean that Ionto is not covered.

The standard treatment for ultrasound therapy (97035) is usually three to four treatments per week or twelve to sixteen treatments per month.

¹ Direct supervision means the therapist must be on site (within the facility).

² General supervision means the therapist should be able to be reached by phone, or another line of communication.

³ PHYSMED-001 is located at http://www.wpsmedicare.com/part_b/policy/physmed001.pdf



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General guidelines for therapeutic procedures 97110 – 97546 are as follows:

- Requires direct one-on-one physical contact
- Plan may include one or a combination of therapeutic procedures
- More general guidelines are available in PHYSMED-009⁴

Documentation for aquatic therapy (97113) must show the medical necessity when the patient's condition requires exercise performed in the water environment. The physician/therapist must be personally present for any aquatic therapy services.

Documentation for manual therapy must show the medical necessity for treatment of restricted motion of soft tissue involved in extremities, neck and trunk.

A physician's order is required when an NPP or a therapist is performing active wound care treatment. Wound care management (non-selective) is a status B code on the MPFSDB and is not separately payable.

Other tests and measurement services may not be billed on the same date of service as the initial PT evaluation per the CCI edits. A PTA is not eligible to perform the evaluation; however, they can assist in the performance.

An initial evaluation is required before therapy begins. The reason for the therapy must be stated in the evaluation. Reimbursement for the evaluation is based on the visit itself and not the time spent performing the evaluation.

Re-evaluation components are similar to evaluation components. Here are examples of when it is medically necessary for a re-evaluation:

- Anytime a patient's condition changes, requiring a change in the therapy plan
- When skilled rehab services are no longer necessary

Once the therapy cap is reached, a re-evaluation is not required, but may be medically necessary.

Page 7 of PHYSMED-009 identifies Ionto coverage guidelines; note no diagnoses are listed. On page 22 a diagnosis listing for Ionto 97033 is omitted, be sure to follow the coverage guidelines.

In 2007 the financial limitations and therapy caps are \$1780.00 for PT and \$1780 for PT and SLT combined.

The CMS IOM publication 100-04, Chapter 5, Section 10.2 discusses the therapy cap information. Providers are responsible for reviewing the IOM guidelines to determine if it is medically necessary for a patient to exceed the cap. Section 10.2 provides a list of conditions or complexities that may possibly exceed the cap. Ultimately it is the contractor's responsibility to determine if the services can exceed the cap. Codes marked as complexities in the Section 10.2 list, are unlikely to require therapy services beyond the cap, unless another condition is present. You may also consider other supportable research, clinical guidelines, and/or clinical/common sense to support the exception process.

Using the KX modifier indicates the service beyond the cap is medically necessary and you have documentation to support that conclusion. You do not need to send any documentation initially to the carrier, but the routine use of a KX modifier might invite some carrier review of your claims.

A coding resource for your use is the MPFSDB. You can access the MPFSDB on the CMS Website⁵. To open it requires unzip software.

⁴ PHYSMED-009 is locate at http://www.wpsmedicare.com/part_b/policy/physmed009.pdf

⁵ The MPFSDB is available at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage>



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Another coding resource is the CCI edits. CCI is available on the CMS Website⁶ and also requires unzip software. CCI shows when two codes will bundle together. Refer to procedure code 97001 and you will see 97750 is bundled into 97001. The “0” in the last column of the table indicates that a modifier is not allowed to make a separate payment for this test.

A provider’s documentation must be complete, legible, and pre-existing. It is the billing provider’s responsibility to maintain all necessary documentation for the services being billed. This includes physician’s information, hospital records, etc. for the services you are billing. Documentation must:

- Substantiate the medical necessity
- Be dated and signed
- Support the diagnosis and services billed

Insufficient documentation may result in an overpayment, or down-coding of your service. The Comprehensive Error Rate Testing (CERT) Website⁷ provides a list of coding errors found within the therapy specialty. Review the CERT Error Focus for your specialty.

Next, we will review claim denial issues. Let’s start with unprocessable codes.

1. Missing/invalid modifier – Make sure you are placing GN, GI, or GP modifiers on the procedure when required. To fix this do the following:
 - a. Verify on the IOM list.
 - b. Call customer service and ask if the system accepts the procedure code/modifier combination.
 - c. Check the modifier section on wpsmedicare.com
2. Invalid procedure code and Modifier – follow the same steps as above.
3. Patient covered under HMO – Make sure to obtain all of the patient’s insurance information when he/she visits the office. The service may need to be billed to a Medicare HMO for payment, or records may need to be updated by Social Security to allow the claim to process.
4. Missing/incomplete/invalid group practice information – Ensure you have the group number in item 33 or the electronic equivalent is in the correct box and matches the provider enrollment information housed by Medicare.

The top therapy claim denials are:

1. Cap has been met – To fix this try checking the IOM for exceptions or it is possible the service is not payable.
2. Service not medically necessary – This is received due to diagnosis or frequency problems. Check PHYSMED-009 to verify the procedure code/ diagnosis code combination. If the service is truly not medically necessary, ensure the patient signs an Advanced Beneficiary Notice (ABN).
3. Duplicate claim/service – 6% of all claims are denied as duplicate and at ninety-six cents per claim, Medicare is spending 5.5 million dollars for duplicates annually. To avoid duplicates, check claims status, or submit only the denied lines on claim.
4. Procedure is considered bundled – Check the MPFSDB to verify the procedure code is not status code “B” and also check CCI.

Thank you for your time today.

⁶ CCI is available at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

⁷ The CERT Website is located at http://www.wpsmedicare.com/part_b/business/cert_legacy.shtml