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Part B Insider (Multispecialty) Coding Alert

Compliance: OIG: 43 Percent of Physical Therapy Claims Didn't Pass Muster

Recent audit showed that just 57 percent of claims were Medicare-compliant.

When it comes to Medicare claims, documentation is everything—and that's especially true for physical therapists, whose payments hinge on a Medicare-compliant plan of care. Unfortunately, the OIG recently found that nearly half of the PTs that the agency audited did not meet the rules, and could be subject to paybacks.

The OIG revealed these findings in its October report, "Boulevard Health Care Program, Inc., Improperly Claimed Medicare Reimbursement for Outpatient Physical Therapy Services." According to the report, auditors reviewed 100 PT claims from the files of Boulevard Health Care, and found that 57 complied with Medicare requirements and 43 did not, totaling $56,664 in inappropriate Medicare payments.

Create a Thorough Plan of Care

The vast majority of inappropriate claims that the OIG discovered during the audit involved services that did not meet Medicare's requirements, mostly involving the plan of care. As many PTs are aware, Medicare only covers physical therapy that is provided "in accordance with a written plan established before treatment begins," the OIG said. The plan must be specific, outlining the type, amount, frequency and duration of the PT, as well as the diagnosis and goals.

The OIG found that for 31 claims, the treatment plan did not include the details of the services that the PT planned to provide. For another three claims, the plan did not include what type of service was provided and billed to Medicare, and for three more claims the plan didn't include the long-term treatment goals.

Plan of care tips: Whomever is furnishing the therapy services must write a plan of care that's consistent with the evaluation. The plan should contain a diagnosis, long-term treatment goals (which should be measurable) and the type of treatment you're rendering, whether it's PT, OT or speech language pathology. You also have to indicate the amount (the number of times a day it will be done), the duration (the total number of weeks or treatment sessions) and the frequency (the number of times in a week) which may taper as the patient progresses in treatment.

The person who creates the plan of care should sign and date it. If any changes are made to the plan of care, it should be signed and dated with the adjustments. A therapist may not alter the plan of treatment established/certified by a physician or non-physician practitioner without their documented written or verbal approval.

Make Sure Documentation Isn't Missing Elements

The remainder of issues that the OIG discovered involved problems with the documentation, including a missing physician certification, no progress report and a completely absent medical record.

Document everything: Your records should include progress reports at least every ten visits that include the PT's assessment of improvement, progress, plans for continuing treatment, changes to goals and functional documentation. In addition, treatment notes for each date of service must outline the treatment dates, which modalities were performed, individual service minutes and total treatment minutes, and the provider's signature.

If your documentation is missing any of these elements, your MAC could—and will—demand that you return any reimbursement you've received for the services in question. Therefore, documenting all of your encounters should be just as important as billing for them.

Resource: To read the OIG report, visit http://oig.hhs.gov/oas/reports/region2/21401004.pdf .