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Part B Insider (Multispecialty) Coding Alert

COMPLIANCE: Therapists--Forget Your John Hancock and You Could Be Out Thousands

Recent OIG audit shows that one therapist's mistakes will cost him over $280,000

You-ve met with the patient, performed the therapy, and billed the services to Medicare using the correct CPT codes, so your reimbursement is all set, right? Wrong. Without accurate documentation, a current plan of care and a signed note, your reimbursement odds go out the window.

The OIG recently announced the outcome of its audit of a Texas physical therapist (PT), and the results were not good. Of the 100 claims that the OIG sampled, not a single one met Medicare's reimbursement requirements, causing Medicare to request $281,325 back from the PT.

In total, 688 of the 702 services that the OIG reviewed failed to qualify for Medicare payment due to a slew of errors, which we-ve summarized below.

1. The therapy documentation did not meet Medicare requirements. Medicare requires therapists to sign the record and document the time spent with the patient, but for 356 therapy services that the OIG audited, the physical therapist's documentation did not support Medicare's regulations.

For example, in many cases the therapist failed to sign the report, and in others, the therapist's documentation didn't support the amount of time that he billed for the patient.

Remember: If you report the timed therapy codes, you should always record how many minutes the PT spent on each modality and report the corresponding number of units on your claim.

Example: A patient had a motor-vehicle accident (MVA) and required a left-leg cast. Following cast removal, the patient had left-leg atrophy, requiring considerable therapy to strengthen it. The physical therapist begins the patient's session with a hot pack on the patient's left leg for six minutes, after which the patient complains of pain, and the therapist removes the pack. The therapist then leads the patient as he performs 27 minutes of therapeutic exercises, 22 minutes of gait training, and 12 minutes of whirlpool.

Solution: In this situation, you would report two units of 97110 (Therapeutic exercises), one unit of 97116 (Gait training), and one unit of 97022 (Whirlpool). You cannot report the six minutes of hot-pack application because it lasted less than eight minutes, which is Medicare's threshold for billing a therapy modality.

2. The PT's PIN was on the claim, but someone else provided or supervised the service. In some cases, the OIG reported, the person billing under the therapist's PIN was actually 120 miles away from the therapist on the date of service.

3. The PT's therapy services were not medically necessary and reasonable. The OIG reported that the PT performed 192 services that were not reasonable and necessary.

For example, the PT billed Medicare for aquatic therapy (97113) but did not document whether the patient had objective loss of joint motion, strength or mobility.

-It's really important to know Medicare's requirements for each code you bill--and not just the national requirements,-

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says **Heather Corcoran**, coder with **CGH Billing** in Louisville, Ky. -That way, if you lack the required criteria to bill a particular code to your carrier, you can have the patient sign an ABN (advance beneficiary notice) up-front,- she says.

4. Plans of care did not meet Medicare's requirements. Medicare will not reimburse therapy services unless the procedures relate to an active plan of care. -Even if you have a plan of care on file, that may not be enough,- says **Randall Karpf** with **East Billing** in East Hartford, Conn. -It has to be signed and dated by the physician at least once a month to make sure it's up-to-date.-

5. Medicare was billed instead of the responsible insurer. In six cases, the OIG reports, the PT billed Medicare for MVA injuries.

-Most of the time, an MVA claim should go to the workers- compensation insurer,- Corcoran says.

6. The PT billed for cardiac rehab, which didn't meet Medicare's requirements. The therapist whom the OIG audited billed for six cardiac rehab services without meeting Medicare's requirements.

-You can only bill for cardiac rehabilitation in the hospital outpatient department or in a clinic where the physician is on-site,- Karpf says.

To read the full OIG report, visit www.oig.hhs.gov/oas/reports/region6/60700061.pdf.

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