

Part B Insider (Multispecialty) Coding Alert

PART B THERAPY BILLING: Medicare Offers Updated Physical Therapy Coding and Billing Rules to Guide Your Claims Submission

Personnel qualifications, policies change in Transmittal 88

If you thought CMS- therapy billing regs were scant and difficult to find, think again--CMS has issued a 53-page transmittal that spells out just about everything you need to bill for therapy services.

Key to the new transmittal: CMS issued Transmittal 88 on May 7, and it offers updates to the outpatient rehab policies.

Treatment plan specifics: CMS now specifies that the therapy duration is the number of weeks, or the number of treatment sessions, -for THIS PLAN of care.-

In addition, CMS notes, -the frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients- goals.-

Keep in mind: Many of the updated regulations in the transmittal (available at www.cms.hhs.gov/transmittals/downloads/R88BP.pdf) simply put into writing what were already requirements for many carriers. Now, these regulations are in writing to allow for uniform billing rules between payers.

[To keep up on your therapy billing and coding techniques, check out these best practices for reporting outpatient therapy:](#)

[Tip 1: Stay in the Bounds of Scope-of-Practice Rules](#)

Your office might shy away from reporting therapy modalities and procedures (97001-97546) because you've heard that only physical or occupational therapists are allowed to report these codes.

Reality: Under Medicare rules, physicians are given full rein to report 97001-97546. However, to play it safe, you may want to review individual payers- coverage policies and state scope-of-practice laws, says **Tammy Johnson**, coder with **Therapy Solutions**.

Each state is a little different, but Medicare will reimburse the physician's therapy services as long as he follows the therapy billing rules (for instance, maintaining a plan of care and documenting the services appropriately), Johnson says.

Remember: Most areas require that the physical therapy be done specifically by the doctor, nonphysician practitioner or physical therapist--and most will not cover the services of a therapy assistant or aide as the primary therapy caregiver. The therapy notes have to reflect who performed the service. This may determine whether the insurance company will pay for the service or not, says **Jay Neal**, an independent coding consultant in Atlanta, Ga.

Tip 2: Support Medical Necessity for PT Service

Once you're in the clear according to your payer, you will still need to meet the standards of a physical therapist by creating a therapy plan specifically geared to each patient and his specific complaint. The main goal of this documentation should be to justify why a particular patient requires--and would benefit from--these services.

An effective PT patient file should include the following:

- A written treatment plan that the clinician creates after an appropriate assessment of the condition (illness or injury). Include documentation of the history, examination, diagnosis, therapy goals and potential for achievement, any contraindications, functional assessment, type of treatment, the body areas to be treated, the date that the therapy was initiated, and expected frequency and duration of treatments.
- Prognosis for potential restoration of function in a reasonable and generally predictable period of time or the need to establish a safe and effective maintenance program.
- Indication that the therapy is working or not working. -This is important to show whether continuation is appropriate,- says **Shannon Mills** with **Mills Billing**.