Eli's Rehab Report

Avoid Common Errors When Billing for Physical Therapy

Nugget: Your notes on the record, along with a complete patient history, may be more important than the CPT code.

The Office of the Inspector General (OIG) reports there are a number of common errors that physical therapists (PTs), occupational therapists (OTs) and coders make when they bill for therapy services, particularly involving those provided in skilled nursing facilities (SNFs).

In a report released in August 1999 the OIG stated that 13 percent of physical and occupational therapy administered in SNFs was billed improperly, while an additional 14 percent was documented improperly. The random sampling of 218 Medicare patients records took place in March 1998, before the implementation of the July 1998 SNF prospective payment system, which now pays SNFs facility-specific per diem rates (including therapy) for each patient in a Medicare Part A covered stay. The OIG report described situations where patients had already reached their treatment goals, the treatment goals were unattainable, therapy was not discontinued at the appropriate time and therapists billed routine maintenance as skilled therapy.

Establishing Plan of Care is Key

Judy Thomas, director of the reimbursement and regulatory policy department of the American Occupational Therapy Association in Arizona explains, Maintenance services are generally considered routine therapy that does not require the skills of an OT. Often, after a person reaches his or her therapy goals an OT will develop a maintenance plan for such things as routine exercises or daily activities that an aide or tech can supervise. Establishing the plan would be considered occupational therapy, but the activities themselves are not.

When a PT does his or her monthly re-evaluation of the patients plan of care, the coder or PT should bill 97002 (physical therapy re-evaluation) instead of billing for a therapeutic service (97110-97139), says **Amy Nasser**, a practicing physical therapist in Kansas City, Mo., who works twice weekly with SNF patients. Many providers wont even pay for general maintenance, which is when theres no real chance of improvement. When were trying to keep someone status quo but not working toward improving their condition, for example in cases of chronic pain resulting from a degenerative nerve disease, we might apply hot packs (97010) or put them in a whirlpool (**CPT 97022**). But we cant bill that the same way we would bill something like manual traction (97140), which is used when were functionally moving toward a goal of either managing pain better, or improving strength, mobility or functions. Unfortunately, many state Medicare carriers do not recognize general maintenance services, which is probably why people were erroneously upcoding to skilled therapy.

Thomas points out that therapists cant always predict the outcome of their services. Sometimes reviewers will treat therapy as maintenance because the patient did not improve sufficiently after a point in therapy. However, at the time therapy was provided, the therapist expected improvement and the services rendered were skilled therapy. Thomas reminds therapists and billers that such situations are the reason its so important that a plan of care demonstrates the need for all services and the clinicians notes document why treatments were offered.

For example, the OIGs office noted that therapy often was administered more than once a day for patients, regardless of the need. Thomas points out that OTs frequently provide interventions related to daily activities such as eating, dressing or personal hygiene that are meaningful to the individual and designed to improve independence; it works best when these interventions coincide with the patients normal routine, such as meal time or activities related to waking up or going to bed.

Additionally, says Nasser, many patients who receive therapy simply cannot handle certain modalities during one therapy session. Im working with a patient right now on improving arm strength so he can use a wheelchair (97542). He

gets tired after one session [15 minutes], so we work together twice a day. The important thing to remember is medical necessity. If you cant prove it, then your therapy services will not be paid.

Documentation Is Crucial

The OIG found that some SNFs billed the documentation of medical records as if that was a skilled service. We cant get reimbursed for documenting a record, says Nasser, but if we do a reassessment of the patients condition and we have to write out a report for the physician, thats kind of thrown in with the modality. For example, I might do 10 minutes of exercise with the patient (97110) and charge for the full 15 minutes. The other five minutes of it is the paperwork. But you cant bill for paperwork alone.

Each SNFs contract with its insurers differs, and you have to be aware of your carriers rules on documentation and billing, says Nasser. But in general, the PTs notes on the record are possibly more important than the CPT code. Its so important to list the patients history, diagnoses, therapy goals and potential for achievement, and frequency and duration of the therapeutic services.

Avoid Erroneous Therapeutic Billing

According to **Judy Thomas**, director of the reimbursement and regulatory policy department of the American Occupational Therapy Association in Arizona, there are three crucial components that can help avoid erroneous therapeutic billing:

1. Learn the payers rules for the setting in which you work. For example, for Medicare skilled nursing facilities (SNFs) patients, you have to follow Medicare coverage guidelines for physical therapists (PTs), occupational therapists (OTs), understand how patients are classified, what type of documentation is required and how the SNF is paid.

2. Improve care plan preparation, patient goals and documentation, and make sure all written material provides clinical reasoning behind decisions regarding treatment, coding and other factors. All care plans should be developed based on the individual patients need, and the treatment and codes should be linked to those in the medical record.

3. Know how to research and use professional literature, such as that provided by associations as well as HCFA and commercial carriers.