Eli's Rehab Report

Compliance: Forget Your John Hancock and You Could Be Out Thousands

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.

Case in point: The OIG recently announced the outcome of its audit of a Texas physical therapist, 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 a therapist to sign the record and document the time spent with the patient, but for 356 therapy services that the OIG audited, this PT'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 must always record the total of time-based code minutes provided on that date of service in addition to the total treatment time (which is the summation of time-based and un-timed CPT codes.)

Example: A patient undergoes a total right knee arthroplasty and begins outpatient physical therapy one week post-surgery. On the first day of treatment, the physical therapist spends 35 minutes evaluating the patient followed by 18 minutes of therapeutic exercise, including instruction in the patient's home exercise program, and nine minutes of gait training.

Solution: In this situation, you would report one unit of 97001 (Physical therapy evaluation), one unit of 97110 (Therapeutic exercises) and one unit of 97116 (Gait training). In addition, you would need to document the timed CPT code minutes and total treatment time. In this case, you would document "timed CPT code minutes: 27, total treatment time: 62 minutes."

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.

Don't miss: Besides the fact that the wrong PIN was on the claim, therapists should have their national provider identifiers (NPIs) by now.

If you've been billing successfully with your NPI-legacy number pair, now is the time to try a small batch of NPI-only claims, CMS said in a message to providers. "If the results are positive, begin increasing the number of claims in the batch." CMS will require NPI-only claims starting May 23.

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," says **Heather Corcoran**, a 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. When this OIG audit took place, the POC had to be signed and dated by the physician at least once a month for all rehab settings, except for CORFs, which were once every 60 days.

Current rule: As of Jan. 1, 2008, any rehab setting, including a CORF, can establish a POC up to 90 calendar days.

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

However, most of the time, MVA claims should go to auto insurance (or workers' comp if the patient was injured while driving on the job), Corcoran says. And you're only hurting yourself if you don't take advantage of auto insurance or workers' comp, which generally offer higher reimbursement than other regular insurance.

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.

Note: To read the full OIG report, visit http://www.oig.hhs.gov/oas/reports/region6/60700061.pdf. To read CMS' documentation and medical-necessity requirements, visit www.cms.hhs.gov.