Codify by AAPC

Eli's Rehab Report

Part B Questions & Answers

The following Q&As have been provided by **Rick Gawenda, PT,** president of Gawenda Seminars & Consulting Inc.

Discharge Report to be Written by Therapist

Question: Under Medicare Part B, can a PTA or OTA write the Discharge Report and have the PT or OT co-sign the Discharge Report?

Answer: The Centers for Medicare and Medicaid Services (CMS) states the Discharge Report shall be a Progress Report covering the time period from the last Progress Report to date of discharge. When CMS uses the word "shall," shall means mandatory. Since Progress Reports must be written by a therapist and not an assistant and Discharge Reports are considered Progress Reports by CMS, this means the Discharge Report is written by a therapist, not an assistant.

For additional information, read Section 220.3D of CMS Pub 100-02, Chapter 15.

Complete the 855R Form before Billing Medicare

Question: I am an OT in private practice; my company has a Group PTAN Medicare provider number. I just started providing PT services two weeks ago. Do my physical therapists need to have a Medicare provider number or is OK to do PT billing under my Group Medicare provider number?

Answer: Each individual therapist in a private practice setting must enroll in the Medicare program. In order to enroll in the Medicare program, the therapist must first obtain a National Provider Identifier (NPI) number. When the therapist enrolls in the Medicare program, they should also complete the 855R form that reassigns payment to the practice via your group NPI number.

Question: If a physician writes an order for the therapy services for 3 times per week for 6 weeks, does the 6 weeks start from the date on the order or from the date that the initial evaluation is performed?

Answer: The answer depends on at least 2 factors: your state practice act/administrative rules and/or the rules and regulations of the insurance carrier. If either one provides guidance of when the order starts, follow the one that is most restrictive. If you don't find an answer from either, then you have to make the decision. My experience is that many insurance carriers start counting the duration from the date of the initial evaluation and not from the date on the order.

Question: Under what CPT® code would you bill fluidotherapy?

Answer: Under the National Coverage Determination for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (150.8), fluidized therapy is a high intensity heat modality consisting of a dry whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having the properties of a liquid. Use of fluidized therapy dry heat is covered as an acceptable alternative to other heat therapy modalities in the treatment of acute or sub-acute traumatic or non-traumatic musculoskeletal disorders of the extremities. Since CMS states this is a dry whirlpool, many insurance carriers and Medicare contractors reimburse for fluidotherapy under CPT® code 97022. However, there are some insurance carriers and Medicare contractors that tell providers to bill for fluidotherapy under 97039 (Unlisted modality).

CPT® 2023 American Medical Association. All rights reserved.