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.

Question: Can you provide any guidance on the use of the "8-minute rule" in the inpatient hospital setting?

Answer: The "8-minute rule" used by the Medicare program only applies to those services reimbursed under the Medicare Physician Fee Schedule (MPFS) that would include outpatient therapy services. If a Medicare beneficiary is admitted in the hospital and has Medicare Part A benefits, the cost of providing therapy services is included in the hospital's diagnosis related group payment. If the Medicare beneficiary has exhausted their Part A benefits or does not have Part A benefits, but does have Part B benefits, then the therapy provided would be reimbursed under the MPFS and the "8-minute rule" would apply.

Question: Must we use a V code as the primary diagnosis on the claim form for outpatient therapy services?

Answer: More and more insurance carriers are not reimbursing for V codes without additional ICD-9 codes on the claim form that provide the reason the patient requires therapy services. V codes tend to be very generic and not fully describe why the patient requires therapy services.

The Centers for Medicare & Medicaid Services (CMS) states in CMS Pub 100-04, Chapter 5, Section 10.3B2:

"As always, when billing for therapy services, the ICD-9 code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors' local coverage determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

"Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code."

In CMS Pub 100-02, Chapter 15, Section 220.3C, CMS states, "A diagnosis (where allowed by state and local law) and description of the specific problem(s) to be evaluated and/or treated. The diagnosis should be specific and as relevant to the problem to be treated as possible. In many cases, both a medical diagnosis (obtained from a physician/NPP) and an impairment based treatment diagnosis related to treatment are relevant. The treatment diagnosis may or may not be identified by the therapist, depending on their scope of practice. Where a diagnosis is not allowed, use a condition description similar to the appropriate ICD-9 code. For example the medical diagnosis made by the physician is CVA; however, the treatment diagnosis or condition description for PT may be abnormality of gait, for OT, it may be hemiparesis, and for SLP, it may be dysphagia. For PT and OT, be sure to include the body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function."