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Eli's Rehab Report

SNF Therapy: Insulate Your Facility from Medical Review

Are you running the risk of duplication of services?

With the **HHS Office of Inspector General's** (OIG's) scrutiny heating up, you need to be cautious when you need to furnish services like ADL training by physical therapists (PTs) in your skilled nursing facility. You'd better make sure that your documentation upholds the need for it, warns **Elisa Bovee**, Sr. Vice President of Operations, **Harmony Healthcare International** in Topfield, MA.

"Typically, occupational therapists (OTs) are likelier to furnish training in activities of daily living (ADLs) than PTs," Bovee reminds us. Therefore, you need to think about the specific therapy goals you're working on for the same patient before reporting 97535 (Self-care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes) on your claim form.

Do this: In situations when both OT and PT need to report 97535 for the same patient, make certain your documentation is airtight and clearly indicates to the payer that the goals for each discipline are different. Otherwise, it could look like duplication of services and your reimbursement would be denied, warns Bovee.

Section GG Increases Focus on Self Care

The primary reason that SNFs need to worry about ensuring their residents receive ADL therapy is that, there is a rising concern about efforts being made to enable patients to go back to the community. Even if the resident isn't returning home permanently, she might need to visit her child or children and would definitely need training on how to transfer from a wheelchair to the bed or vice versa without causing injury, says Bovee. The therapy goals here would include improving the functional performance of the patient, including physical mobility limitation, stability, strength, range of motion, and coordination. (For more on Section GG see box on page 52.)

Warning: However, you should not use 97535 when the therapy goal is strengthening. Instead, look to this code when the therapy is intended to improve the patient's functioning. Medicare typically covers 97537 when the patient presents with a medical barrier and functional deficits requiring training to reach specific functional goals such as community transportation, shopping skills and work environment adaptation for re-entry into the community. The patients likeliest in need of such training would be those who have recently suffered from stroke, a cardiac event, a severe fracture, or those who suffer from multiple sclerosis, or Parkinson's disease, Bovee says.

Since PTs typically focus on strengthening of muscles, you need to report codes like 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

Other code choices include 97112 (... neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities) or 97140 (Manual therapy techniques [e.g., mobilization/manipulation, manual lymphatic drainage, manual traction], one or more regions, each 15 minutes) depending on what service you rendered, Bovee advises.

Though 97530 (Therapeutic activities, direct [one-on-one] patient contact by the provider [use of dynamic activities to

improve functional performance], each 15 minutes) reimburses more, you should exercise caution when using it. But, if much of the therapy plan of care centers around fulfilling the needs of Section GG and returning to community, 97530 could be your code of choice, Bovee adds. Just keep in mind that you need to report for services you actually performed not what you think the payer wants to see on your claim.

Code with Payer in Mind

For Medicare payers you will report G0283 (Electrical stimulation [unattended], to one or more areas for indication[s] other than wound care, as part of a therapy plan of care). However, for private payers submit 97014 (Application of a modality to one or more areas; electrical stimulation [unattended]) if you use stimulation as a warm-up modality instead.

Fear of Medical Review Is Real

Not only does your claim require a therapy treatment ICD-10 code so the carrier will pay it, but you also need to label your patient's condition correctly to avoid future coverage complications. Payers want to see a specific treatment diagnosis as the primary ICD-10 code on therapy claims.

"Choice of codes affect reimbursement of Part B patients. Billing for Part A patients is not affected so much unless there is a medical review; especially the Probe & Educate reviews," says Bovee. And Part A providers shouldn't get too comfortable the threat of medical review is very real and could become a reality any given time.

Even if you do receive payment with an incorrect ICD-10 code, you risk problems with reimbursement down the line. Medicare and private carriers both have physical therapy policies that list specific frequency limitations and other coverage guidelines for every diagnosis, and you may find that your patient is eligible for far less coverage than he needs if you're reporting the wrong diagnosis.