Eli's Rehab Report

Therapy Claims: Tighten Up Your Claims With These 10 Tips

Hint: Medicare may not reimburse all therapy modalities on same day service.

Do you keep an eye on the calendar when you file your claims? While Medicare doesn't always require a physician's prescription, your local state laws might. These and other issues that you need to watch out for to keep your bottom line in the black were discussed in **NGS Medicare's** Aug. 12 webinar, "Outpatient Physical and Occupational Therapy Billing and Coding."

1. Confirm expectation of improvement. Outpatient therapy services are only payable when furnished in accordance with the following conditions, said **Judy Brown, CPC,** a provider outreach and education consultant with NGS Medicare, during the webinar: "For restorative therapy, there must be an expectation that the patient's condition will improve significantly in a reasonable period of time. The services must be skilled in nature, meaning they require the professional skills of a therapist."

2. Physician orders may be required. "This is something we get asked all the time, because it's a confusing topic," Brown said. "At one time, Medicare required that you get a physician's prescription in order for the patient to come in for physical therapy. However, Medicare took that requirement away that is no longer a requirement for Medicare. With this being said, if your state law says you have to have a physician order to do therapy services, then you're going to do that," she added. Although a physician order is no longer a Medicare requirement, check your state law or ask your state association for specific requirements.

3. Make sure your plan of care is complete. Whoever is furnishing the therapy services must write a plan of care that's consistent with the evaluation. "The plan has got to contain a diagnosis, long-term treatment goals (which should be measurable) and the type of treatment you're rendering, whether it's PT, OT or speech language pathology. You also have to indicate the amount (the number of times a day it will be done), the duration (the total number of weeks or treatment sessions) and the frequency (the number of times in a week) which may taper as the patient progresses in treatment," Brown added.

The person who creates the plan of care should sign and date it. If any changes are made to the plan of care, it should be signed and dated with the adjustments. "A therapist may not alter the plan of treatment established/certified by a physician or non-physician practitioner without their documented written or verbal approval," she noted.

4. Keep an eye on the calendar. "The progress reporting period is up to every ten treatment days, so every ten treatment days that you see the patient, you have to do a progress report," Brown said.

5. Make sure the therapy qualifies as "skilled." To qualify for Medicare payment, the services must require the professional skills of a therapist, Brown said. "If a parent, husband, wife, caretaker of any kind, a nurse, an aide can supply the services, then that's not really considered 'skilled' and Medicare would therefore deny the claims," she said.

6. Maintenance therapy is not covered. "Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibilities and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes," Brown said. These so-called "maintenance services" will be denied.

7. Maintenance programs are allowed. Despite Medicare's rule that it won't cover maintenance therapy, you can get payment for a "maintenance program," Brown clarified. If the clinician develops a maintenance program to maintain the functional status of a patient and prevent decline (such as in patients who have diseases that cause deterioration), you

can typically collect from Medicare for that. This can include training the patient's family about how to help carry out therapy services that will help the patient prevent deterioration.

8. Report one initial evaluation. When a patient presents with a problem for which he requires physical therapy, you should report just one initial evaluation that covers all related complaints and problems that the PT evaluates at the same time. "If, however, over the course of treatment, a new, unrelated diagnosis occurs, then another initial evaluation can be covered," Brown added.

If a PT performs the initial evaluation, you'll report 97001 (Physical therapy evaluation); if an OT does it, report 97003 (Occupational therapy evaluation); and if a physician or NPP performs the evaluation, report the appropriate E/M code such as 99212 instead, Brown said.

9. Report reevaluations when necessary, said **Linda Teti, CPC,** a provider outreach and education consultant at NGS Medicare, during the call. "A reevaluation is not a routine, recurring service, it's not billed to complete an updated plan of care, it's not a recertification report and it's not a progress report," she said. "Reevaluations would include new clinical findings, and significant changes in the patient's condition that were not anticipated in the current plan of care."

When PTs perform reevaluations, you'll bill 97002, and if OTs perform them, 97004 is the code to report. If a physician or NPP performs a reevaluation, report an E/M code such as 99213.

10. MACs look for multiple modality overbilling. "It's not often that a patient would require more than one or two modalities to the same body part during a therapy session," Teti said. If a patient does require multiple modalities on the same site on the same day, you should "carefully justify" them in the medical record, she added.