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Eli's Rehab Report

Therapy Procedures, Goals and Documentation Determine When to Bill ADL Code

Occupational therapists spend a great deal of time helping patients readjust to the activities of daily living (ADL) following serious injury or disease. Code 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) is used often enough that it is known as the "ADL code." Consider the following before billing the ADL code, keeping in mind that CPT offers alternative codes that may prove more accurate to your particular situation.

How Is the Patient Being Trained?

Judy Thomas, MGA, director of reimbursement and regulatory policy for the American Occupational Therapy Association (AOTA) in Bethesda, Md., says use of the ADL code often centers on whether the patient is "practicing" an activity that he or she will use in day-to-day life. "Many of the other therapy codes relate to specific performance skills or interventions that prepare a person for engaging in the activities that he or she needs to do. Use of the ADL code, however, usually means that the occupational therapist is using the actual (or simulated) activity as the therapy intervention." For example, a therapist training a stroke patient to eat without assistance will appear at mealtime to help with adaptive utensils, setting the table, etc. "The ADL itself becomes the therapeutic activity, which is why therapists often use environmental modules, like bathrooms, kitchens, even cars, to simulate environments where ADL needs to take place," Thomas says.

What Is the Goal of the Therapy?

The way the therapist documents the patient's training may help determine whether to use the ADL code. "The therapist's goals should be related to an occupation-based activity and not just a performance skill," Thomas says. For example, an intervention that includes exercises "to increase shoulder flexibility to facilitate independence in dressing" would be coded 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility). However, if the documentation reads, "To compensate for limited shoulder range of motion, the therapist worked with the patient on upper-extremity dressing using adaptive techniques and equipment," it's clear that the therapist is using dressing as the intervention activity, and that should be coded 97535.

Laureen Jandroep, OTR, CPC, CCS-P CPC-H, CCS, consultant and certified professional coder trainer for A+ Medical Management and Education in Absecon, N.J., offers the following examples of ADL training:

1. A hip-replacement patient must use dressing sticks and other reaching equipment to bathe and dress his lower extremities, since the post-hip replacement precautions are not to bend past 90 degrees. The therapist practices using the reaching equipment with the patient for 30 minutes in his room during his usual bathing and dressing time and codes two units of 97535.

Note: Some Medicare carriers' ADL policies state that it is not usually medically necessary to conduct more than 30 minutes of ADL training on any given day, unless multiple traumatic injuries are being treated. Check with your carrier before billing any ADL service so you can determine appropriate time limitations.

2. A carpal tunnel patient who recently underwent right carpal tunnel decompression surgery (64721, Neuroplasty and/or transposition; median nerve at carpal tunnel) must learn how to perform certain activities using one hand. The therapist

works with the patient on cooking, dressing, bathing, walking her dog, and grocery shopping while using the left hand only.

3. A lower-back-pain patient must lessen strain on her back. The therapist teaches the patient how to perform kitchen activities using a stool or sitting at the kitchen table, where to place her toiletries and cooking supplies to minimize twisting of the lower back, how to sit most comfortably when driving, and the appropriate way to carry her handbag and avoid lifting her child while standing.

4. A cook with rheumatoid arthritis must learn joint-protection techniques. The therapist teaches the patient how to get on and off the bus using "side stepping" to preserve joint function and lessen pain. In addition, the therapist works with the patient in a mock kitchen on adapting to utensils that put the least amount of joint strain on the hands, fingers and wrists.

Not a Catchall Code

Code 97535 should not be used in every case, because circumstances will dictate which code is most appropriate. "Coding is not an exact science and often has a lot to do with the payer's perception of what a code means," Thomas advises.

For instance, some coders may see "wheelchair training" in the chart and instantly assume that 97542 (Wheelchair management/propulsion training, each 15 minutes) is correct. The fact is that 97542 "is intended to be used with clients who have the ability or potential for independent operation of the wheelchair," Thomas says. "Therefore, it is not an appropriate code for nursing-home patients who will never be able to propel themselves independently." She says that 97542 would be billed when training someone to operate an electric wheelchair safely on different terrains or to turn corners, "issues in handling a wheelchair independently in whatever environment the person needs to be."

Thomas recommends that a therapist assisting a wheelchair-bound patient with compensatory techniques to facilitate ADL bill either 97112 (Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities) or 97535, depending on the circumstances.

Code 97535 might be used for wheelchair training for a patient who recently suffered a stroke and is now confined to a wheelchair around her home.

The therapist may teach the patient how to transfer from the wheelchair to the bath or bed, how to cook from the seated wheelchair position, or how to use reaching equipment for items placed high on grocery-store shelves.

Documentation Is Key

Documentation is key to supporting your claim, particularly when something as complex as ADL training is performed. "I generally advise therapists to document so that their rationale for selecting a code is clear and supportable," Thomas says. "If you then have a difference of opinion with the payer, that's all it is, a difference of opinion. At that point, they need to work out the procedures so that everyone knows what is being done and how the payer expects to see the coding."

Although carrier requirements differ from state to state, most Medicare providers maintain similar documentation guidelines for use of the ADL code.

These policies are often not put into writing, however, leaving PM&R coders frustrated over what information is required to process these claims.

The following documentation requirements, taken from the policy of First Coast Service Options (Part B provider in Florida), may help practices gain a better understanding of what information should be maintained when billing for ADL

training:

There must be clear documentation that the patient has a medical or surgical condition that prevents him or her from performing ADL.

The physician ordering ADL training must have taken a history from the patient, examined the patient, and established an etiology or diagnosis for the patient's medical condition.

The physician ordering ADL training must specify the type and duration of ADL training he or she is ordering.

The ADL trainer must clearly document the type of services provided to the patient for each date of service. There should be a statement concerning the patient's progress, as well as a statement on the time required to provide the service.

A physician billing for physical therapy services is required to maintain an established plan of treatment as a permanent part of the patient's clinical record. The plan must be established before the treatment is begun. The physician must see the patient at least every 30 days and must review, initial and date the plan of treatment. The plan must be kept on file in the physician's office and available for carrier review if requested.

A therapy plan of treatment must include the type, amount, frequency and duration of the services that are to be furnished to the patient and indicate the diagnosis and anticipated goals.

Any changes in the treatment plan must be made in writing and signed by the physician. While the physician may change a plan of treatment established by the therapist providing the services, the therapist may not alter a plan of treatment established by a physician.