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# Physical/Occupational Therapy Billing

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

# Today's Presenters

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# Objectives

- Review Medicare billing and coverage guidelines that apply to physical/occupational therapy services
- Provide appropriate resources and tools in order to find additional information for your practice

# Agenda

- Plan of Care
- Certifications/Recertifications
- Physical Therapy and Occupational Therapy Initial Evaluation
- Modalities
- Progress Reports
- Treatment/Discharge Notes

# Agenda

- Maintenance Care
- Documentation Requirements
- Services provided by PTA/OTA
- KX Threshold
- Appeals Process
- Resources

# Medical Necessity

# Medical Necessity

- Rehabilitative Therapy
  - Condition has the potential to improve or is improving from therapy
  - Maximum improvement is yet to be attained
  - Expectation that improvement is attainable in a reasonable and generally predictable period of time
  - Services must be skilled in nature

# Physician Order/RX

- CMS IOM states: "**No Medicare requirement** for an order/RX"
- Payment is dependent on certification of the POC rather than physician order/RX
- State laws may require physician order/RX

# Plan of Care

# Plan of Care

- Developed by the physician/NPP or PT/OT who will provide the PT/OT services
  - Must be certified by a physician/NPP
- Signature/credentials of the therapist or physician/NPP must be present and dated
- Each therapy discipline must have a separate plan of care

# Plan of Care - Goals

- Improve functioning
  - Must require the skills of a therapist
- Maintain, prevent or slow further deterioration
  - Must require the skills of a therapist

# Required POC Elements

| Required POC Elements | Additional Points |
|---|---|
| Diagnosis | Diagnosis should be specific and relevant to the problem |
| Long Term Goals | • Pertain to the functional impairment findings documented in the evaluation<br>• Reflect the final level the patient is expected to achieve<br>• Be realistic, and should have a positive effect on the quality of the patient's everyday functions<br>• Be **function-based** and written in objective, measurable terms with a predicted date for achieving the goals |

# Required POC Elements

| Required POC Elements | Additional Points |
|---|---|
| Type of Treatment | Therapy discipline operating under this POC (PT or OT) and should describe the types of treatment modalities, procedures or interventions to be provided |
| Amount of Treatment | Number of times in a day the type of treatment will be provided |
| Frequency of Treatment | Number of times in a week that the type of treatment is provided |
| Duration of Treatment | Number of weeks, or the number of treatment sessions, for this plan of care |

# Changes to the Therapy Plan

- Changes made in writing in patient's record and signed by professional responsible for patient's care
- Physician/NPP may change a plan of treatment established by the therapist
- Therapist may not alter plan of treatment established/certified by physician/NPP without their documented written/verbal approval

# Plan of Care Modifiers

- GO
  - Services delivered under an **outpatient occupational therapy** plan of care
- GP
  - Services delivered under an **outpatient physical therapy** plan of care

# POC Errors

- Missing physician's or NPP's dated signature certifying the POC
- Missing signature of the physician's, NPP's or therapist who developed and established the treatment plan and date of establishment
- Missing significant POC changes
- Missing modifiers
- Missing POC certifying provider's name and NPI on the claim

# Certifications/Recertifications

# Certifications/Recertifications

- Requires dated signature on POC or some other document that indicates approval of plan of care
- Acceptable forms of certification determined by practitioner
  - Physician's progress notes
  - Physician/NPP order
  - Plan of care signed/dated by physician/NPP and indicates they are aware therapy is in progress and does not disagree with plan

# Certifications/Recertifications

- Certifications
  - Physician/NPP certifies the initial POC with a dated signature or verbal order within 30 days of the first day of treatment
    - Verbal orders must be signed and dated within 14 days
  - Delayed certification must include a reason for the delay
    - Physician did not sign
    - Original was lost
  - Certifications without justification will be acceptable up to 30 days after the due date
- Recertifications
  - Timely when dated during the duration of the initial plan or
  - Within 90 calendar days of the initial treatment

# Certifications/Recertifications

- Interval length shall be determined by *the patient's needs, not to exceed 90 days*
- Certifications will be valid for the longest duration in the plan
  - Example: three times/week for six weeks, total 18 treatments
- Treatment continued past the longest duration specified will require recertification

# Certifications/Recertifications

- For claims where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service
  - Include the providers name and NPI, in the appropriate referring provider loop (or appropriate item on Form CMS-1500)

# Skilled Therapy

# Skilled Therapy

- Services that require professional skills of a therapist to perform or supervise
- Patient's therapy that can proceed safely and effectively through a home program are not skilled services
  - Exercise
  - Self-management
  - Restorative nursing
  - Caregiver assisted

# Personnel Authorized/Not Authorized to Provide Outpatient Therapy Service

# Personnel Authorized to Provide Outpatient Therapy Service

- Physician
- Nonphysician practitioner
- Qualified PT/OT, SLP, assistants working under the supervision of a qualified therapist
- Qualified personnel, with or without a license to practice therapy
  - Must be educated and trained as a therapist and
  - Qualified to furnish therapy services under direct supervision incident to a physician/NPP

# Personnel **Not** Authorized to Provide Outpatient Therapy Service

- Students
- Aides
- Athletic trainers
- Exercise physiologists
- Massage therapists
- Recreation therapists
- Kinesiotherapists
- Low vision specialists
- Pilates instructors
- Rehab technicians
- Life skills trainers

# Therapy Students

- Services of therapy students are **not covered** under Medicare even under line of sight supervision by a therapist
- However, services of a qualified professional are covered, even when student is participating in care
  - Must direct the service
  - Not be engaged in treating another patient
  - Must sign all documentation

# Incident to Services

- Services may be provided by a therapist incident to the services of a physician/NPP
  - Therapist does not need a license to practice therapy
    - State law may require
  - All other PT/OT qualifications must be met
  - Must be directly supervised
    - The physician must be immediately available to furnish assistance and direction throughout the performance of the procedure
    - Physician does not need to be present in the room when the procedure is performed

# Physical Therapy and Occupational Therapy Initial Evaluation

# Physical Therapy and Occupational Therapy Initial Evaluation

- **Initial evaluation** should document necessity of therapy through objective findings and subjective patient/caregiver self-reporting
- If over the course of an episode of treatment a **new unrelated diagnosis** occurs another initial evaluation may be covered
- Initial evaluations may be performed for other therapy disciplines
  - Evaluation and POC must not be duplicative

# Reevaluations

- Progress toward current goals, making a judgment about continued care, modifying goals or/treatment or terminating services
  - New clinical findings
  - Significant change in patient's condition
  - Failure to respond

# Modalities

# General Modality Guidelines

- **Modalities** selected based on the most effective means of achieving the patient's functional goals
- **Seldom** should a patient **require more** than one or two modalities to the same body part
  - Use of more than two modalities on each date is unusual and requires documentation

# General Modality Guidelines

- Multiple heating modalities should not be used on the same day
- Documentation must support the use of multiple modalities as contributing to the patient's progress and restoration of function

# General Modality Guidelines

- LCD and billing and coding article list the guidelines for each specific code
- Based on the CPT descriptors, these modalities apply to one or more areas treated
- Documentation requirements outlined

# Modality Example

- CPT 97034 – Contrast Baths (to one or more areas)
  - Contrast baths are a form of therapeutic heat and cold applied to distal extremities in an alternating pattern
  - The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold
  - Not covered when the services provided are hot and cold packs
  - Should be used in conjunction with therapeutic procedures, not as an isolated treatment
  - Constant attendance code requiring direct, one-on-one patient contact by the provider
  - Only the actual time of the provider's direct contact with the patient is to be billed
- Supportive Documentation Requirements (required at least every ten visits)
  - Rationale requiring the unique skills of a therapist to apply, including the complicating factors
  - Area(s) being treated
  - Subjective findings to include pain ratings, pain location, effect on function
  - Documentation must indicate the presence of these complicating factors for reimbursement
  - If there are no complicating factors requiring the skills of a therapist, this modality is noncovered

# Therapeutic Guidelines

# Therapeutic Guidelines

- Attempt to reduce impairments/restore function through the application of clinical skills and/or services
- Use of these procedures is expected to result in improvement in a reasonable and generally predictable period of time

# General Guidelines for Therapeutic Procedures

- Codes will define if direct one-on-one contact is required
- Only the actual time of direct contact will be considered
- Expected goals of the treatment plan need to be documented
- Any one or a combination of these procedures may be used

# Progress Reports

# Progress Reports

- Provides justification for the medical necessity of treatment
- Written by the clinician at least **once every ten treatment days**
- Required Elements
  - Date of the beginning and end of the reporting period that this report refers to
  - Date that the report was written by the clinician, or if dictated, the date on which it was dictated
  - Objective reports of the patient's subjective statements, if they are relevant
  - Objective measurements (impairment/function testing) to justify continued treatment

# Progress Reports

- **Required Elements**
  - Changes in status relative to each goal currently being addressed in treatment
  - Make identifiable reference to the goals in the current plan of care
  - Assessment of improvement, extent of progress (or lack thereof) toward each goal
  - Plans for continuing treatment, including documentation of treatment plan revisions as appropriate
  - Long or short term goals, discharge or an updated plan of care
  - Signature with credentials of the clinician who wrote the report

# Treatment Notes

# Treatment Notes

- Required for every treatment day and therapy service
- **Required Elements**
  - Date of treatment
  - Identify each specific treatment, intervention or activity provided
  - Record the total time spent (represented by timed codes and untimed code treatment minutes)
  - Record of total treatment in minutes (sums the timed codes and untimed code treatment minutes)
  - Signature and credentials
    - Include on grid or checklist used for daily notes/activity log

# Treatment Notes

- Exercise names alone do not imply that the services were skilled in nature
- Functional activities should be documented including the skilled techniques used
- Time for each specific intervention/modality may be recorded

# Unbillable Charges

- Changing
- Waiting for treatment to begin
- Waiting for equipment
- Resting
- Toileting
- Performing unskilled or independent exercises or activities

# Discharge Notes

# Discharge Notes

- Required for each episode of treatment
- Written by the clinician
- Covers from the last progress report up to the date of discharge
- Includes all components of a progress report

# Maintenance Program

# Maintenance Program

- Established when the skills of a therapist are required to safely and effectively furnish to maintain, prevent or slow further deterioration of the patient's functional status
- Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary's need for skilled care
  - Can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel
  - Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program

# Maintenance Program

- While a beneficiary's particular medical condition is a valid factor in deciding if skilled (rehabilitative or maintenance) therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled
  - The key points is whether the skills of a qualified therapist are needed, or whether the service(s) can be carried out by non-skilled personnel

# Other Available Therapy Services

- Muscle and range of motion testing
- Application of casts, strapping and splinting codes
- General guidelines for casting
- General guidelines for strapping
- Special instructions for strapping; Unna boot
- General guidelines for splinting
- Biofeedback training by any modality
- Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day
- Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

# Miscellaneous Services (Noncovered)

- Anodyne
- Low level laser treatment (LLLT)/cold laser therapy
- Dry hydrotherapy massage (e.g., aquamassage, hydromassage or water massage)
- Massage chairs or roller beds
- Interactive metronome therapy
- Loop reflex training
- Vestibular ocular reflex training
- Continuous passive motion device setup and adjustments
- Craniosacral therapy
- Electro-magnetic therapy, except as indicated for chronic wounds
- Constraint Induced Movement Therapy Work-hardening programs

*Not an all-inclusive listing, see LCD L33631

# Documentation Requirements

# Documentation Requirements

- Include
  - Medical history, physical exam, results of diagnostic test and procedures, time of any assessment
  - Must be legible, relevant and sufficient to justify the medical necessity
- Reminder
  - POC, initial evaluation, certification/recertification should also be included in the record

# Documentation Requirements

- Legible identifier of the person who provided the service
  - Handwritten or electronic signature to sign an order or other medical documentation for medical review purpose
  - Electronic or handwritten signatures that have been communicated through facsimile are also acceptable
- Medical review decisions are based on the information submitted in the medical record
- Critical that your medical record information submitted is accurate and complete to allow medical review to make a fair decision

# Documentation Requirements

- Paint a picture of the patient's impairments and functional limitations requiring skilled intervention
  - Describe prior functional level to assist in establishing the patient's potential and prognosis
  - Describe the skilled nature of the therapy treatment provided
  - Justify the type, frequency and duration of therapy
  - Clearly document both timed code treatment minutes and total treatment time

# Utilization Guidelines

# Utilization Guidelines

- Untimed Codes
  - Not defined in CPT by a specific time frame
  - Document as "Total Treatment Time"
  - Often provided once per day
    - Significant documentation is required when performed more often
- Timed Codes
  - Count time the patient is treated using skilled therapy
  - Document as "Timed Code Treatment Minutes"

# Timed/Untimed Physical Therapy Billing Codes

# Timed Codes

- Many CPT codes used for therapy modalities, procedures specify that direct (one-on-one) time spent with the patient is 15 minutes
- Services provided for a single timed CPT code that is less than eight minutes should not be billed however, if multiple procedures are performed at the same session the minutes can count towards total treatment time

# Eight Minute Rule Reference Chart

| Minutes | Units |
|---|---|
| 8–22 minutes | One unit |
| 23–37 minutes | Two units |
| 38–52 minutes | Three units |
| 53–67 minutes | Four units |
| 68–82 minutes | Five units |
| 83 minutes | Six units |

# Timed Code Example One

- CPT codes 97110 and 97140
  - 20 minutes of 97110
  - 20 minutes of 97140

  Add all minutes= 40 minutes of total timed codes
- Three billable units
  - Two units for code 97110 , One unit for code 97140
    - Provider selects how they are spilt

# Timed Code Example Two

- CPT Codes 97035 and 97110
  - Five minutes of 97035
  - Seven minutes of 97110

  Add all minutes= 12 minutes of total timed codes
- One billable unit

# Timed Code Example Three

- CPT codes 97110 and 97140
  - Seven minutes of 97110
  - 18 minutes of 97140
- Add all minutes= 25 minutes of total timed codes
- Two billable units
  - One unit of 97110
  - One unit of 97140

# Untimed Codes

- Do not have a time requirement
  - Typically provided to a patient only once per day
- Only one unit of these codes are billed regardless of how long they are performed to the patient
  - These codes are billed as one unit but are not included in the totaling of the timed code units
    - Reevaluation codes are untimed, billable as one unit

# Miscoded Services

- Do not bill for
  - Documentation time
  - Codes higher than what was performed
  - Codes based on reimbursement amount
  - Supplies separately
- Therapist working as a team cannot each bill for the same or different service provided at the same time

# Service Provided In Whole or In Part by an OTA/PTA

# Service Provided In Whole or In Part by an OTA/PTA

- Effective 1/1/2022
- Identify and make payment at 85% for services furnished in whole or part by PTAs/OTAs
- Allowed at 85% of the MPFSDB
- Modifiers
  - CQ – Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
  - CO – Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
  - Use in conjunction with one of the existing therapy modifiers (GP, GO)

# Service Provided In Whole or In Part by an OTA/PTA

- Claims must include modifier CQ or CO when
  - PTA/OTA furnishes all the minutes of a service independent of the PT/OT
  - PTA/OTA furnishes a portion of a service separately from the part that is furnished by the PT/OT
  - PTA/OTA portion exceeds ten percent of the total minutes for that service
    - Ten percent is the de minimis standard
    - Use the simple method or the percentage method to calculate the de minimis standard

# Service Provided In Whole or In Part by an OTA/PTA

- In cases where a PT/OT and PTA/OTA provide care independent from one another but the PT/OT meets the 15 minute requirement, CMS will not apply the de minimus standard
  - Would be billed without a CQ/CO modifier
    - In this case any minutes furnished by the PTA/OTA would not apply for billing purposes

# De minimus Example One

- PT or OT renders 24 mins of CPT 97110
- PTA or OTA renders ten mins of CPT 97110
  - Add up the total treatment time: 34 mins
  - Two billable units can be billed in total under the PT/OT without counting the assistance minutes since the eight min rule was met by the 24 mins of 97110

# De minimus Example Two

- PT/OT provides 20 min of 97140/ 12 min of 97110
- PTA/OTA provides 14 min of 97110
  - Add up the total treatment time: 46 min (three billable units)
  - One unit is billed under the PT/OT for 97140
  - One unit is billed under the PT/OT for 97110
  - One unit is billed under the PTA/OTA for 97110 with a modifier of CO or CQ

# De minimis Exceptions

- Final 15-minute unit left to bill, the "eight-minute rule" is applied when the PT/OT furnishes eight or more minutes (the Medicare billing requirement for that final 15-minute service unit) – that final unit is billed without the CQ/CO modifier because the PT/OT provided enough minutes on their own (more than half) to report the service
- Two units of the same service remaining to be billed, and the PT/OT and the PTA/OTA each furnish between nine and 14 minutes of a 15-minute timed service where the total time of therapy services furnished in combination by the PTA/OTA and PT/OT is at least 23 but no more than 28 minutes, one unit of the service is billed with the CQ/CO modifier (for the unit furnished by the PTA/OTA) and one unit is billed without it (for the unit furnished by the PT/OT)

# KX Threshold

# KX Modifier

- CY 2023 KX modifier threshold amounts
  - $2,230 for PT and SLP services combined/$2,230 for OT services
- 2023 Medical record threshold amount
  - PT/SLP $3,000/OT $3,000
  - Will remain $3,000 until CY 2028

# KX Modifier

- Documentation must support and justify that the beneficiary qualifies for the therapy cap exception, that services are reasonable and necessary, as well as require the skills of a therapist
- The presence of the KX modifier demonstrates that services billed
  - Qualify for the annual threshold
  - Are reasonable and necessary services that require the skills of a therapist
  - Are justified by appropriate documentation in the medical record
- Therapy services submitted without the KX modifier for claims above the therapy threshold will deny

# KX Modifier

- For medically necessary services use the GO, or GP therapy modifier, in addition to the KX modifier
  - KX modifier should **not** be added to any line of service that is not a medically necessary service
- Codes subject to the therapy threshold posted annual
  - Annual Therapy Update

# Medical Review Additional Development Request Documentation

# Medical Review Therapy Documentation Checklist for ADR Letters

- Refer to the checklist below when preparing your documentation in response to an ADR
  - Doctor's orders
  - Certifications/recertifications
  - Initial evaluations
  - Any reevaluations and documentation of medical necessity for reevaluations
  - Any pertinent diagnostic testing and results

# Medical Review Therapy Documentation Checklist for ADR Letters

- Therapists' notes for dates of service
- Logs/treatment records/encounter sheets indicating: date, time, type and duration to support units billed
- Plans of treatment, goals, and progress towards goals
- Progress notes since onset of therapy

# Medical Review Therapy Documentation Checklist for ADR Letters

- Any abbreviation keys or acronym keys used
- Copies of any patient notices given (e.g., ABN)
- Documentation to support level of supervision requirements met if applicable
- Documentation to support any other services billed in conjunction with therapy services
- Documentation of practitioner's credentials

# Appeals

# Reopening versus Redetermination

| Reopening<br><br>To correct a claim(s) determination resulting from minor errors | Redetermination (Appeal – First level)<br><br>For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation |
|---|---|
| • Mathematical or computational mistake<br>• Inaccurate data entry<br>• Computer errors<br>• Incorrect data items<br>• Transposed procedure or diagnostic codes | • Coverage of furnished items and service<br>• Overpayment determinations<br>• Medical necessity claim denials<br>• Determination on limitation of liability provision |

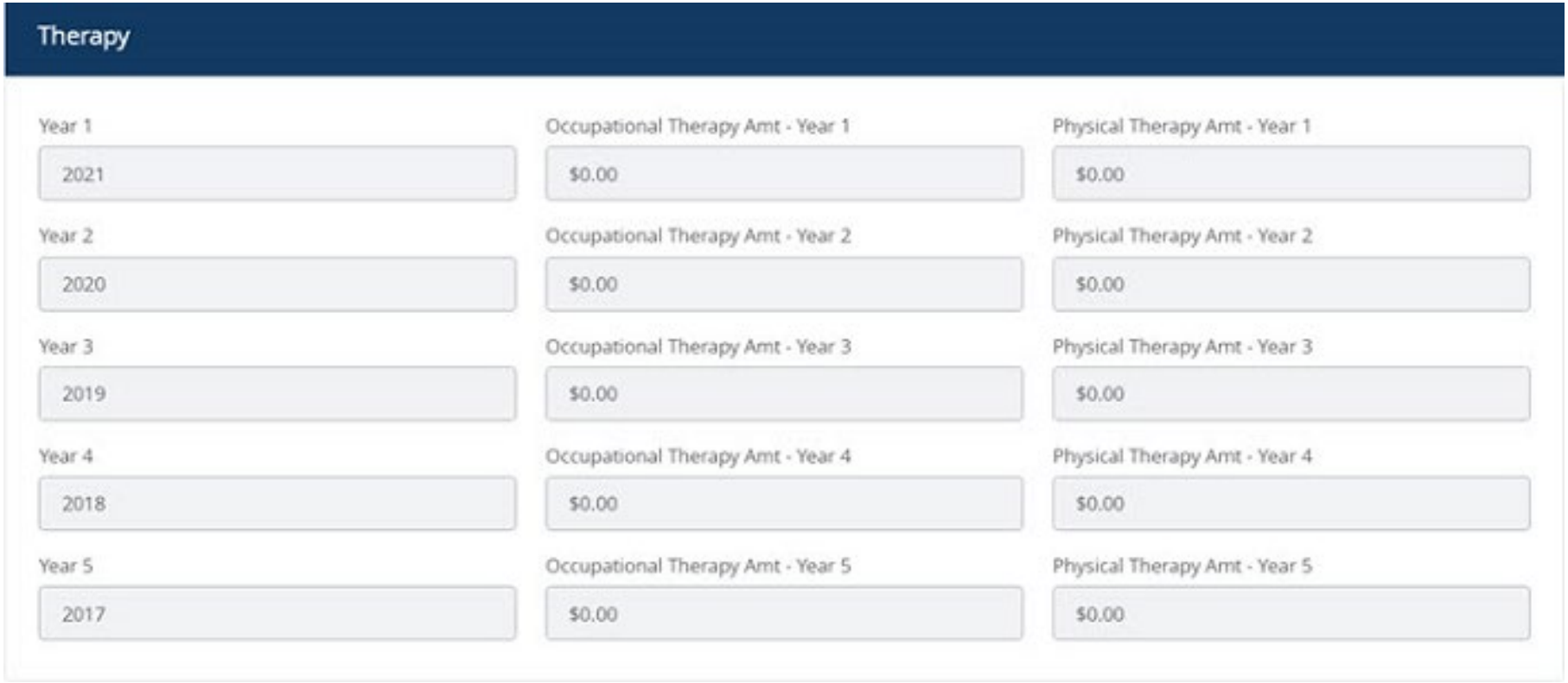
# Modifier Appeals

- Adding/changing a modifier
  - Excluding modifiers AQ, AR, QU, QB, 22, 23, 52, 53, 62, 66, GA, GY and GZ
  - KX modifier can be initiated through a reopening in NGSConnex or on a Reopening Request Form
  - Reopenings for Minor Errors and Omissions

# NGSConnex

- Free, secure, web-based application
  - Submit claims
  - Obtain beneficiary eligibility information
  - Submit documents for ADR requests (Medical Review only)
  - Initiate and check status of redetermination and reopening requests
  - View duplicate/claim overlaps

# NGSConnex Therapy Information



# "What if" and Scenario Questions

- MACs cannot provide a definitive answer on whether Medicare would make payment for a service
  - MACs can only provide information on Medicare rules and regulations, the final determination is based on information contained in an individual patient's medical record
- MACs may not provide a preliminary medical review determination based on snippets of information or documentation
  - Final determination of payment is made after the submission of the claim and any medical review that may be performed
  - MACs will not grant prior approval or affirm a provider's individual practice's procedures, coding or documentation are sufficient to meet all Medicare guidelines
- Remember, providers are responsible for determining the correct diagnostic and procedural coding for the services furnished to Medicare patients
- After reviewing Medicare guidelines, providers, compliance, audit and/or billing staff can find more information on coding resources in CMS IOM Publication 100-09, *Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual,* Chapter 6, Section 30.3.1

# Resources

# Resources

- 2022 Therapy Code List
- CMS Therapy Services web page
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 12
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 5

# Resources

- Outpatient Physical and Occupational Therapy Services LCD L33631
- Outpatient Physical and Occupational Therapy Services Billing and Coding Article A56566
- MLN® Fact Sheet: *Complying with Outpatient Rehabilitation Therapy Documentation Requirements*

# Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?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