

Frequently Asked Questions
APTA “The Source” Audio Conference
“Medicare 2008 – Changes for Physical Therapy”
December 12, 2007

Therapy Cap

Q: Is the 2008 therapy cap of \$1810 the allowable rate or actual payment received?

A: The Medicare program will pay 80% of \$1810 and the beneficiary is responsible for the remaining 20%. This is based on allowed charges.

Q: Why do the therapy caps not apply in outpatient hospital departments?

A: When Congress passed the Balanced Budget Act of 1997, outpatient hospital departments were excluded from the therapy cap. Congress wanted to create a “safety net” for Medicare patients who exceed the cap. There was no specific rationale for Congress choosing outpatient hospitals as the “exempt” setting.

Q: Is it okay to offer Medicare patients an “aftercare” program if they use up the cap at a reduced rate or flat fee? What if the PT or PTA is also certified as a Personal Trainer or CSCS?

A: If a patient has exceeded the cap in 2008 and there is **no** exceptions process, a physical therapist can continue treatment; however, the beneficiary will be financially responsible for these services. CMS recommends that you give the beneficiary a Notice of Exclusion of Medicare Benefits (NEMB); however, it is not mandatory that you provide the beneficiary a NEMB. If the patient exceeds the cap, the provider is not required to bill Medicare. If the service is statutorily non-covered, the claim could be submitted using the GY modifier indicating the service is non-covered by statute.

If a PT is providing “maintenance care” then usually these services are not covered by Medicare. Please see the language below regarding circumstances under which the Medicare program will cover the development of a maintenance program.

When charging patients out of pocket, it is very important to have a set fee schedule that applies to all patients regardless of their insurer (Medicare or private insurance). Additionally, any discounts offered should also be offered to all patients regardless of their source of insurance coverage and all discount policies should be established in writing. For instance, you may have a policy that offers a 20% discount to patients with income less than a certain dollar amount in a given year or for patients with medical costs that exceed a set limit in a given year.

Any additional training or certifications a PT has, such as a personal trainer, does not make a difference in the reimbursement rate or the charges under the Medicare program nor does it affect the coverage of a maintenance program.

Language From Medicare Benefit Policy Manual (below)

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> (pg. 160)

D. Maintenance Programs

During the last visits for rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized skill, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.

Where a maintenance program is not established until after the rehabilitative therapy program has been completed (and the skills of a therapist are not necessary) development of a maintenance program would not be considered reasonable and necessary for the treatment of the patient's condition. It would be excluded from coverage under §1862(a)(1) of the Act unless the patient's safety was at risk (see below).

EXAMPLE: *A Parkinson patient who has been under a rehabilitative physical therapy program may require the services of a therapist during the last week or two of treatment to determine what type of exercises will contribute the most to maintain the patient's present functional level following cessation of treatment. In such situations, the design of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist, the instruction of the patient or family members in carrying out the program, and such infrequent reevaluations as may be required would constitute covered therapy because of the need for the skills of a qualified professional.*

Evaluation and Maintenance Plan without Rehabilitative Treatment.

After the initial evaluation of the extent of the disorder, illness, or injury, if the treating qualified professional determines the potential for rehabilitation is insignificant, an appropriate maintenance program may be established prior to discharge. Since the skills of a therapist are required for the development of the maintenance program and training the patient or caregivers, this service is covered.

EXAMPLE: *The skills of a qualified speech-language pathologist may be covered to develop a maintenance program for a patient with multiple sclerosis, for services intended to prevent or minimize deterioration in communication ability caused by the medical condition, when the patient's current medical condition does not yet justify the*

need for the skilled services of a speech-language pathologist. Evaluation, development of the program and training the family or support personnel would require the skills of a therapist and would be covered. The skills of a therapist are not required and services are not covered to carry out the program.

Skilled Maintenance Therapy for Safety.

If the services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may be necessary for the safe and effective delivery of such services. When the patient's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

Example. Where there is an unhealed, unstable fracture, which requires regular exercise to maintain function until the fracture heals, the skills of a therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

Q: With the new cap of \$1810 for Part B PT/SLP benefits, how does the cap count toward the patient responsibility of 80%? For example, in outpatient, the patient is responsible for 20% of allowable charges (unless they have a secondary insurance). Is the patient allowed to spend all the way up the cap of \$1810 or only 80% of the cap (\$1448) for their maximum yearly allowable?

A: Medicare will pay 80% of the allowed charges (\$1448.00) and the beneficiary will be responsible for the remaining 20% (\$362.00)

Q: Will the exceptions process continue for the rest of 2007?

A: The exceptions process will continue until June 30, 2008. After that date, Congressional action will be necessary to extend the exceptions process.

Q: What is the cap for occupational therapy services?

A: \$1810.

Q: If a Medicare beneficiary has therapy in an outpatient hospital department (exempt from the cap) and later goes to a private practice, does the private practice have to include any money spent by Medicare at the hospital based facility?

A: No. None of the visits from the hospital accrued toward the cap.

Physician Fee Schedule

Q: Does the 10.1% reduction in Medicare fee schedule include the Part A rehab agency?

A: Since the date of this audio conference, Congress changed the 10.1% negative update to a 0.5% positive update until June 30, 2008. After that Congressional action will be necessary to prevent the 10.1% negative update from going into effect. All outpatient therapy services are billed under the physician fee schedule and therefore this reduction would apply to all outpatient therapy services. A rehabilitation agency furnishes outpatient therapy services and therefore would be subject to this reduction.

Q: Is the 9% reduction in payment overall for PT services?

A: The reduction discussed on the call of 9% is an overall aggregate reduction in payment for all outpatient physical therapy services. The amount of payment reduction for each individual CPT code would differ. (Please note that after the date of the audioconference Congress passed legislation changing the 10.1% reduction in the conversion factor to a .5% increase until June 30, 2008).

Q: How would I get more information regarding Medicare geographic areas?

A: Information on the GPCIs can be found at the following CMS website:

http://www.cms.hhs.gov/PFSlookup/03_PFS_Document.asp

Physician Quality Reporting Initiative (PQRI)

Q: Who is eligible to participate in the 2008 PQRI?

A: In 2008, physical therapists in private practice and occupational therapists in private practice that submit claims to Medicare carriers using the 1500 claim form or 837-P are the **only** settings that are able to participate in the quality reporting initiative and obtain the bonus. Each physical therapist in private practice obtains his/her NPI number which is placed on the claim form. This NPI number is then used to track whether there was successful reporting on the quality measure.

Q: How are the PQRI Measures in 2008 quantified in regards to 1.5% bonus? For example, is it that the more measures that are performed the higher the bonus payment?

A: The PQRI has two basic requirements. The first is that if you have three or more measures, you must report on at least three. In 2008, PTs have eight measures to choose from for reporting purposes. For each measure you report on, you must report on that measure 80% of the time. So if you see ten patients in a year to whom a particular measure would apply, you must report that quality measure on at least eight of those ten patients to qualify for the bonus. It would be best to pick measures that apply to the types of patients you see most often in your practice.

The bonus is set at 1.5 percent. For example, it does not increase if you report on six measures as opposed to four or five measures.

Q: Where would I get more info on the PQRI?

A: There are two sources of information on the PQRI. Refer to the links below for information:

www.cms.hhs.gov/pqri

www.apta.org/pqri

Q: What is the general feedback from providers who participated in the PQRI program? Did they get their bonus check?

A: The PQRI began July 1, 2007 and will conclude for 2007 on December 31, 2007. CMS will then be able to conduct a more in depth analysis of how many providers participated, their success rate, gather provider feedback, and provide confidential feedback reports to providers. Bonus payments for the 2007 PQRI will be made in mid-2008. Payment for the 2008 program, which will run from January 1, 2008-December 31, 2008, will be made in 2009.

Referrals and the Plan of Care

Q: Does the Medicare program require a referral/prescription/order for outpatient physical therapy services?

A: In most outpatient settings, the Medicare program does not require an order/referral for physical therapy services. However, if your state requires a referral, then it would be necessary and you must comply with all of the requirements associated with it under state law. For instance, your state might dictate what is to be included with the referral (such as goals, duration, etc) and/or how often a referral is necessary. Regardless of whether your state requires a referral you need to have a plan of care certified/recertified in accordance with Medicare regulations.

Q: In what settings does the new 90 day recertification time line apply?

A: The 90 day recertification time line applies to outpatient therapy services provided in the following settings: rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (Part B services only), outpatient hospital settings, private practices, home health services (Part B only).

Q: Can you confirm that Pennsylvania does not have direct access as of yet for Medicare?

A: The state of Pennsylvania has a prescribed path in order for a PT to practice with direct access. If you have met these requirements, you may see a Medicare patient without a referral.

Q: Can any physician certify or recertify the plan of care? What is the requirement for payment without a referral other than medical necessity for skilled therapy services?

A: With respect to outpatient therapy services a physician (meaning a doctor of medicine, osteopathy, podiatric medicine (when within the scope of practice) or optometry (for low vision rehabilitation only) can certify or recertify a plan of care. There is no requirement in most outpatient settings for a referral. However, the patient must be under the care of a physician and a physician must certify/recertify the plan of care.

Payment is contingent upon the services being medically necessary and the documentation requirements, such as the plan of care, being met.

According to the Medicare manual:

“Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. It is not appropriate for a physician/NPP to certify a plan of care if the patient was not under the care of some physician/NPP at the time of the treatment or if the patient did not need the treatment.”

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> (pg. 152)

Q: Is there any time frame where the patient must obtain a new referral?

A: The Medicare program does not require a referral unless your state law does. If your state law requires a referral, it will likely dictate how often or when this referral must be renewed. After January 1, 2008, Medicare will require an initial plan of care be signed by the physician as soon as possible (at least within 30 days) and that recertification of the plan occur every 90 days, unless the physician specifies an earlier date.

Q: I work at a hospital based therapy department. Our therapists provide care to both inpatients and outpatients. We frequently receive referrals from physicians that specify the patient’s diagnosis and the request for “PT- Evaluate and treat.” Following the evaluation of an outpatient, the therapist determines the recommended treatment (modalities, etc) and the frequency. The goals for treatment are included in the Plan of Care and it is sent to the physician for signature. Treatment is often initiated during that evaluation visit. According to the 2008 Rule, the plan must be established before treatment begins. While the plan of care is determined immediately after the evaluation, we cannot immediately get the physician’s signature. Does the rule imply that the Plan of Care must be returned with the physician’s signature before beginning treatment?

A: No, the Medicare program only requires that the plan be established. It does not require that the plan be certified by the physician before treatment can begin. The PT should immediately send the plan of care to the physician; however, the PT has 30 days from the first therapy encounter to obtain the physician signature on the plan of care.

Q: Are physical therapists allowed to bill for the plan of care? Is the code the same as a progress note?

A: The plan of care and progress notes are both considered part of the documentation and the Medicare program does not pay for documentation. Documentation services are considered to be part of other services such as the evaluation (97001).

Q: Does the 90 day recertification period apply to both Medicare A and Medicare B residents in a SNF? Does the fact that we bill for the services provided to our outpatient beneficiaries on the UB-04 form make a difference?

A: The 90 day recertification period applies only to the Medicare Part B residents in the SNF. Skilled nursing facilities use the UB-04 form for both outpatient and inpatients and use of this form does not impact the policy on the 90 day recertification.

Q: Can you tell me if there are any Medicare regulations or policies on whether or not a private practice can determine how many Medicare referrals they will take?

A: Medicare does not dictate how many referrals a practice may take at a given time.

Q: Does occupational therapy and speech-language pathology follow the same guidelines as physical therapy for the 90 day recertification period? Or do these specialties still need to complete the recertification every 30 days?

A: All three therapy specialties will transition to the 90 day recertification requirement on January 1, 2008.

Q: For any outpatient insured patient (Medicare Part B or private insurance) accepted under direct access, does the 90 day recertification have to be attained if the course of treatment is less than 30 days?

A: For Medicare patients, if the course of treatment is less than 30 days, there is not need to recertify the plan of care unless the physician specifies that he/she wants to review and recertify the plan of care prior to the 30 day time frame. For services paid by private insurance, the answer to this question would vary depending on the insurance policy coverage.

Q: Does Medicare pay the same amount for patients treated under direct access as for those referred by a physician?

A: Yes, there is no difference in the reimbursement level based on a state's direct access provisions.

Q: Where can one find information on direct access laws for a particular state?

A: APTA has information available on direct access laws for each state at the link below:

http://www.apta.org/AM/Template.cfm?Section=Top_Issues2&CONTENTID=43482&TEMPLATE=/CM/ContentDisplay.cfm

Q: If state law does not require a referral, how often does the patient need to see the physician or do they have to at all as long as the Plan of Care is signed and current?

A: Under Medicare there is no requirement for a physician visit unless the physician specified that he/she would like to see the patient in a certain time frame.

Q: When did the 30 certification/recertification period go into effect?

A: The 30 day recertification requirement has existed since 1988.

Documentation

Q: Which of these are true regarding progress reports?

- **Must be given every 10 visits or 30 days.**
- **Includes remeasurements, etc**
- **Billed as an extension of the ther-ex units**
- **Needs to be included in patient record**
- **Need not be signed by physician**
- **Is OT under same requirements?**

A: Progress reports must be completed every 10 visits or once during the certification interval, whichever is less. Regulations regarding what must be included in the progress can be found in Chapter 15 of the Medicare Benefit Policy Manual at the link and page number below. Progress reports do not need to be signed by a physician but must be included in the patient's medical record. Occupational therapists are required to follow this requirement as well.

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> pg. 169

Q: According to Medicare regulations, the Daily Treatment notes may meet the minimal requirements for the 10-day Progress Report as described in Transmittal 63. In section "D. Progress Reports", it states:

The Progress Report provides justification for the medical necessity of treatment. Contractors shall determine the necessity of services based on the delivery of services as directed in the plan and as documented in the Treatment Notes and Progress Report. It is not required that the referring or supervising physician/NPP sign the Progress Reports...

Early Reports ... Elements of Progress Reports may be written in the Treatment Notes if the provider/supplier or clinician prefers. If each element required in a Progress Report is included in the Treatment Notes at least once during the Progress Report Period, then a separate Progress Report is not required.

As a result of this guidance, our practice revised our Daily Treatment Notes so that they meet the requirements of a Progress Report. Our process is that the daily notes suffice as

the 10-day Progress Note and we continue to write a formal Progress Report at least every 30 days. The formal Progress Report goes to the physician. My question is: Are the 10-day Progress Notes (which for us is in the daily notes) required to be sent to the physician or are they only required to be kept in the chart for medical necessity reasons?

A: No, the progress report and daily treatment notes or encounter notes are not required to be signed or sent to the physician but must be maintained in the patient medical record.

Q: Can we change the long term goals without getting a new physician signature on the plan of care?

A: If you are changing the long term goals, then you are making a significant change to the plan of care and a physician signature would be necessary. An insignificant alternation for which a signature would not be required would be a decrease in the frequency or duration due to the patient's illness or a modification of short-term goals to adjust for improvements made toward the same long-term goals.

PT/PTA Qualification Standards

Q: I am a South African trained physical therapist and have passed the licensing exam in 2005. I worked in Boston for 2 years and I have been practicing in Florida for 10 years under a valid Florida license. Do I now need to determine whether the university I graduated from in South Africa is a CAPTE approved PT program?

A: No. You would meet the definition of physical therapist under Medicare and would not need to update your qualifications after 2010.

Q: Will technicians be allowed to provide therapy care in the acute hospital after July 2008? How will Medicare be able to distinguish the therapy care for payment without auditing as the notes are usually signed by the PT or PTA?

A: After July 2008 in the acute care hospital setting, physical therapy services must be provided by an individual meeting the definition of physical therapist or physical therapist assistant. A technician could provide a service in the hospital, but this service would not be considered a physical therapy service. Medicare could identify who provided a particular service by conducting an audit. Without auditing, it is difficult to identify the personnel providing services in the hospital setting.

Q: As a licensed PTA, I would implement exercise and modalities per the PT's plan of care. Would it be acceptable for a licensed massage therapist to implement only the soft tissue massage treatments as written up/designated by the PT in the plan care when indicated?

A: If a massage therapist provided soft tissue massage treatments, these treatments would not be considered physical therapy services and thus would not be considered as part of the implementation of a physical therapy plan of care.

Q: With the new PT and PTA definitions, were there any changes in PTA supervision rules specific to SNFs?

A: The supervision requirements for PTAs has not changed as a result of this rule. APTA has a supervision chart which identifies the supervision requirements for the various practice settings. It can be found at the link below:

http://www.apta.org/AM/Template.cfm?Section=Assistants_Aids_Students&Template=/MembersOnly.cfm&ContentID=25894

Comprehensive Outpatient Rehabilitation Facility (CORF)

Q: Regarding the Centers for Medicare and Medicaid Services (CMS) clarification on location of service in the home being okay as long as another Medicare payment is not being made for home health. Does this also apply to location of services provided by the OT, PT and SLP furnished by a rehabilitation agency?

A: No, this clarification only applies to services provided by a certified comprehensive outpatient rehabilitation facility (CORF) that delivers services to Medicare beneficiaries. An outpatient rehabilitation facility (ORF) is allowed to provide services in extension locations such as freestanding facilities and office suites with certain stipulations (please see §2298A at <http://www.cms.hhs.gov/manuals/downloads/som107c02.pdf>).

Q: I work in a hospital based outpatient center within the "4 walls" of the main hospital. We provide PT, OT and SLP. Would the CORF requirements pertain to us? It was my understanding that an outpatient facility was a CORF if they fell outside the main building from the hospital.

A: To answer your question, we would need more information to further analyze the structure of your entity. Being physically housed within an inpatient hospital alone is not sufficient to designate your facility as a CORF. You would need to consider factors such as services provided, billing mechanisms, and contractual relationships with other entities such as the hospital.

Here is some information for consideration:

A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician (please see §2360 at <http://www.cms.hhs.gov/manuals/downloads/som107c02.pdf>) With the exception of financial management contracts, the responsibility for overall administration, management, and operation must be exercised by the CORF itself and not delegated to others.

The CORF provides a broad array of services that must include, at a minimum, the following three core services: physician services, physical therapy services and social work or

psychological services. A CORF may be owned by, or affiliated with, a legal entity operating as another type of Medicare provider. The requirement for functional and operational independence does not require separate incorporation. Coordination between such entities in relation to personnel, equipment, and facilities is permissible if it is undertaken in accordance with §2364. The requirement for functional and operational independence is to assure that any entity seeking approval as a CORF meets the requirements for such approval and that the costs of different Medicare providers are clearly identified, segregated, and attributed to the proper provider. When certifying a CORF, it is important to understand the relationship of space, equipment, and employees shared with other providers and suppliers.

National Provider Identifier (NPI)

Q: We have had significant billing issues with Medicare since August with electronic claims. Today, we were notified that we must not only include NPI numbers for PTs and referring doctors, but also the tax ID numbers for the referring physicians. Is this true? The clearing house is blaming Medicare for this new change which was not sent to us as a notification.

A: Until March 1, 2008, PTs in private practice (those who use 837P and CMS-1500 claims) can place one of the following options on the claim form:

- their legacy number (UPIN) only, or
- their legacy and NPI number, or
- their NPI only on the claim form.

Starting March 1, 2008, PTPPs must place their NPI in the primary field on the claim form. This means that the PT can put both their NPI and legacy numbers on the claim form or their NPI only. The Medicare program expects that only the NPI will appear on the claim form after May 23, 2008.

Until May 23, 2008, Medicare only requires the legacy numbers for referring physicians, although if the physician has an NPI this can also be placed on the claim form. After May 23, 2008, the referring physician's NPI must be on the claim form.

Beginning 1/1/08, Medicare will require NPIs to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. Until May 23, 2008, Medicare only requires the legacy numbers for referring physicians, although if the physician has an NPI this can also be placed on the claim form. After May 23, 2008, the referring physician's NPI must be on the claim form.

We are not aware of any requirement that the tax ID numbers for the referring physicians be included on your claim form. You should check with your Medicare contractor regarding this issue.

More information regarding use of the NPIs is available on CMS's website at:
<http://www.cms.hhs.gov/nationalprovidentstand/>

Q: If a therapist is out ill or on vacation, is it appropriate to continue billing under that therapist or do we have to bill under the covering therapist?

A: It would not be appropriate to bill for the services of a “substitute” PT under another PT’s NPI number. All services should be billed through the NPI of the provider who delivered the service.

Coding

Q: In a skilled setting, can the minutes associated with wheelchair measurements be counted as applicable RUGS minutes?

A: If the service is considered a skilled physical therapy service, then it would count toward the RUGs minutes.

Q: Where can I get more information regarding the telephone and on-line assessment codes (98966 to 98969)?

A: More information regarding the telephone and on-line assessment codes is available on APTA’s website at the link below:

<http://www.apta.org/AM/Template.cfm?Section=Coding&Template=/MembersOnly.cfm&ContentID=44056>

Q: In a skilled setting, when a licensed PT and PTA are ambulating a patient can the minutes for both clinicians be counted? For instance, if it took 15 minutes to ambulate a patient who was assisted by a PT and PTA, would the allowed minutes be 15 or 30?

A: Medicare does not count minutes of “co-treatment.” In the scenario described above the allowed minutes would be 15 minutes.

Q: I am currently looking into adding Medicare to my private practice. In looking at the 2008 Medicare calculator 97014 says “not recognized by Medicare, use G0283.” Is this the code to reimburse for interferential electrical stimulation?

A: Yes. For Medicare, use G0283 to bill for interferential electrical stimulation.

Q: With respect to 8 minute rule can you comment on choice of billing for the following scenario.

- a. Patient was seen for a total of 55 minutes which would allow billing of 4 units
 - i. 50 minutes therapeutic exercise and a 5 minute ultrasound.
 1. Can I bill 4 units therapeutic exercise 97110
 2. Or must I bill 3 units 97110 and 1 unit 97035

ii. 49 minutes exercise and 6 minutes ultrasound

1. Does this change my billing options

A: You should count the total direct contact time and bill for the services you believe you spent the majority of your time and best describes the services provided.

CMS has included information that can provide helpful guidance in a Transmittal available at the following link:

<http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf>

Q: Regarding the new non-Medicare reimbursed CPT codes regarding patient conferencing and telephone interaction with a patient. Is there any reason to take the time to report them since they are not reimbursable? It seems like more work for no reimbursement. Or is there some Medicare rule requiring it to be placed on the bill?

A: You do not need to include these CPT codes on your bill to Medicare unless you want to receive a denial notice.

Q: It was mentioned that not more than 4 units of therapy should be billed in 1-hour, does this include modalities?

A: In the same 15-minute time period, one therapist may bill for more than one therapy service occurring in the same 15-minute time period where "supervised modalities" are defined by CPT as untimed and unattended -- not requiring the presence of the therapist (CPT codes 97010 - 97028). One or more supervised modalities may be billed in the same 15-minute time period with any other CPT code, timed or untimed, requiring constant attendance or direct one-on-one patient contact. However, any actual time the therapist uses to attend one-on-one to a patient receiving a supervised modality cannot be counted for any other service provided by the therapist.

Q: In regards to the discussion about "no more than 4 units billed per hour," does this apply to only Medicare? For instance, what if you are treating a Medicare patient and a private patient and a portion of the treatment overlaps? Does Medicare expect us to take into consideration all patients being treated in a given hour or just Medicare patients?

A: If a CPT code requires direct one-on-one patient contact, then it would be necessary to be one-on-one with the Medicare patient. It is not feasible for a physical therapist to be one-on-one with a Medicare beneficiary if that therapist is also providing a direct contact service to a private insurance patient.

Q: Units/day: 32 units are available per day for attended units. If adding unattended units to the treatment, is that in addition to the attended units? If so, is there a limit of unattended units that can be given for one patient's treatment? For one day of treatments considering all patients?

Scenario: Patient is scheduled 1:00 to 1:45, the first ½ hour for 2 attended units of treatment, the next ¼ hour for 1 unattended unit of treatment. Time documented in patient record is 45 minutes (1:00 to 1:30 for attended units and 1:30 to 1:45 for unattended unit). The next patient is scheduled for 1:30 to 2:15, the first ½ hour for attended units of treatment, and the next ¼ hour for 1 unattended unit of treatment. There is now an overlap of time (1:30 to 1:45) that patients were being treated and that is recorded in their records. Is this acceptable?

A: It is possible that the amount of units billed per day could exceed 32 units if unattended services are provided. The overlap you described in the scenario above would be acceptable. More information specifically related to billing of units is available in the following CMS Transmittal: <http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf>

Q: For a skilled nurse facility setting, can you tell me the maximum number of Medicare Part A patients who can be seen by one therapist during the same time frame before it is considered a group charge?

A: The Long Term Care Resident Assessment Instrument Questions and Answers clarifies how to account for therapy provided to an individual within a group setting. It states that if the group has four or fewer participants per supervising therapist (or therapy assistant under general supervision by the therapist) then it is appropriate to report the full time as therapy for each patient. The example used is that of a therapist working with three patients for 45 minutes on training to return to the community. Each patient's MDS would reflect receipt of 45 minutes of therapy for this session. Although we recognize that receiving PT, OT, or ST as part of a group has clinical merit in select situations, we do not believe that services received within a group setting should account for more than 25 percent of the Medicare resident's therapy regimen during the SNF stay. For this reason, no more than 25 percent of the minutes reported in the MDS may be provided within a group setting. This limit is to be applied for each therapy discipline; that is, only 25 percent of the PT minutes reported in the MDS may be minutes received in a group setting and, similarly, only 25 percent of the OT, or the ST minutes reported may be minutes received in a group setting.

To summarize, the minutes of therapy provided by at least one supervising therapist (or therapy assistant under general supervision by the therapist) within a group of four or fewer participants, may be fully counted, provided that those minutes account for no more than 25 percent of the resident's weekly therapy in that discipline, as reported in the MDS. The supervising therapist may not be supervising any individuals other than the four or fewer individuals who are in the group at the time of the therapy session. Naturally, provision of group therapy time in excess of the 25 percent threshold is allowable, but those minutes may not be counted in section P of the MDS for purposes of RUG-III classification for Medicare Part A beneficiaries.

Enrollment

Q: In reference to the question regarding exclusive use of the pool (community pool) as a requirement for billing. It appears through previous posted Q&A on the APTA site that

the exclusivity only applies to using the #11 as the “place of service;” therefore, it appears that exclusivity is not imperative for billing. May we continue to use the community pool for therapies and continue using the code #12 for place of service? Isn’t another form 855 required for this as well as home use? And how would the reverse apply: Say for instance a physical therapy clinic IS the place of the community pool, and “members” are enjoying the PT pool the same time that a patient is being seen? Does this rule of not being able to bill for therapy apply?

A: Currently Medicare regulations require exclusive use of the pool during the time physical therapy is being provided. The manual language has been provided for your convenience below.

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> pg. 186

Services should be furnished in the therapist’s or group’s office or in the patient’s home. The office is defined as the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in the practice at that location. If services are furnished in a private practice office space, that space shall be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. For example, a therapist in private practice may furnish aquatic therapy in a community center pool. As required in other settings (such as rehabilitation agencies and CORFs), the practice would have to rent or lease the pool for those hours, and the use of the pool during that time would have to be restricted to the therapist’s patients, in order to recognize the pool as part of the therapist’s own practice office during those hours. Therapists in private practice must be approved as meeting certain requirements, but do not execute a formal provider agreement with the Secretary.

Q: Where can I apply to become a Medicare participant?

A: Please use the following link to find out how to become a Medicare provider. APTA also has resources regarding provider enrollment which may be helpful.

CMS Provider Enrollment

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

APTA Enrollment Resources

http://www.apta.org/AM/Template.cfm?Section=Become_a_Provider_Supplier&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=166&ContentID=36012

Q: Where can I find the outpatient private practice rules?

A: There are two sources of information on Medicare policies. One is the APTA website, a link to which has been provided below. The second is Chapter 15 of the Medicare Benefit Policy Manual, Sections 220 and 230.

APTA Medicare Resource Center

www.apta.org/medicare

Supervision Requirements for Staff

Q: We also need to know if the rules regarding use of therapy aides has changed under Medicare rules (A and B). My current understanding is that an aide can assist a resident or outpatient with lower skill level activities, and that 'individual attention' from the aide can be counted as therapy if there is therapist 'line of sight' supervision. Is this correct now, and if so, will the new definitions change this?

A: APTA has developed an aide supervision chart that explains the various supervision level requirements for the various practice settings. It can be found at the link below:

http://www.apta.org/AM/Template.cfm?Section=Assistants_Aids_Students&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=25893

Q: Is it true that licensed PTA notes do not require co-signature by a licensed PT?

A: Under Medicare a PTA's daily notes do not require the co-signature of a licensed physical therapist unless the state law requires the co-signature.

Medicare specifies the involvement a PTA may have in the various elements of the patient medical record. A PT may include the "objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others."

For daily treatment of encounter notes, Medicare requires the following:

"Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment (i.e., the signature of Kathleen Smith, PTA, with notation of the help of Judy Jones, PT, supervisor, when permitted by state and local law). The signature and identification of the supervisor need not be on each Treatment Note, unless the supervisor actively participated in the treatment, but the supervisor's identification must be clear in the Plan of Care, or Progress Report. When the treatment is supervised without active participation by the supervisor, the supervisor is not required to cosign the Treatment Note written by a qualified professional. When a supervisor is absent, the presence of a similarly qualified supervisor on that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation. Since a clinician must sign the Progress Report, the name and professional identification of the supervisor shall be included in the Progress Report."

The regulations regarding the PTA participation in the progress note are listed below:

Assistant's Participation in the Progress Report

Physical Therapist Assistants or Occupational Therapy Assistants may write elements of the Progress Report dated between clinician reports. Reports written by assistants are not complete Progress Reports. The clinician must write a Progress Report during each Progress Report Period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the clinician's report. Progress Reports written by assistants supplement the reports of clinicians and shall include:

- Date of the beginning and end of the reporting period that this report refers to;
- Date that the report was written (not required to be within the reporting period);
- Signature, and professional identification, or for dictated documentation, the identification of the qualified professional who wrote the report and the date on which it was dictated;
- Objective reports of the patient's subjective statements, if they are relevant. For example, "Patient reports pain after 20 repetitions". Or, "The patient was not feeling well on 11/05/06 and refused to complete the treatment session."; and
- Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively. For example: "increasing strength" is not an objective measurement, but "patient ambulates 15 feet with maximum assistance" is objective.

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the Progress Report may be used to add, change or delete short term goals. Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name, and date. Clinicians verify these changes by co-signatures on the report or in the clinician's Progress Report. (See section 220.1.2(C) to modify the plan for changes in long term goals).

The evaluation and plan of care are considered incorporated into the Progress Report, and information in them is not required to be repeated in the report. For example, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current Progress Report Period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3,) and the short term goals that relate to the long term goals may be numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. A clinician, an assistant on the order of a therapist or qualified personnel on the order of a physician/NPP shall add new goals with new identifiers or letters. Omit reference to a goal after a clinician has reported it to be met, and that clinician's signature verifies the change.

Q: Were there any changes to levels of supervision for 2008? Is there increased freedom allowing clinics to bill for the prep time that is being done by directly supervised, unlicensed staff, during an 80 minute visit that includes 55 minutes of PT:pt time?

A: There were no changes regarding level of supervision for 2008. There have been no changes regarding billing for preparation time by directly supervised unlicensed staff. These services are not considered billable under Medicare.

Q: Currently rehab techs are used together with registered therapists, with line of sight supervision, for Part A patients in a SNF setting. When the new definitions for personnel are implemented, will the ability to use rehab techs will go away? Because this is in the SNF setting, will the effective date of this be July 1, 2008?

A: The effective date of personnel standards in the skilled nursing facility setting is July 2008. CMS plans to issue further guidance in the next few months related to the questions you raised. When that guidance is issued, APTA will make sure to notify our membership.

Q: If we offer in-home Physical Therapy to Medicare patients as a private practice, can these services be rendered by a PTA under general supervision, or can they only be rendered by a PT or PTA under direct supervision?

A: For physical therapists in private practice, it is necessary to provide direct supervision (meaning in the office suite—or present) of the physical therapist assistant. Therefore, the physical therapist would need to be present in the patients home when these services are rendered. General supervision would not be acceptable.

Home Health Agencies

Q: Has there been any discussion as to whether CMS will make changes to the consolidated billing rule?

A: We do not anticipate that CMS will change its home health consolidated billing rule. Such a change would require Congress to pass legislation.

CMS has issued guidance for PTs to help them determine whether a patient is covered under a home health plan of care. This information can be found at the APTA website.

http://www.apta.org/AM/Template.cfm?Section=Home_Health1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=171&ContentID=18286

Private Payers

Q: Advantra Freedom is ever growing in our area. All state employees that previously had Medicare with Wells Fargo, TPA as secondary have all switched to Advantra Freedom. When asked, they say they follow all Medicare guidelines. However, they state that they do not have a therapy cap. From a legal standpoint, can they do this considering they "follow

Medicare guidelines?" I have asked Medicare, Wells Fargo, and Advantra Freedom this question. None of them have an idea. Please help us.

A: If it is not a Medigap plan, legally a secondary insurer can determine the services that it will cover. If a secondary insurer chooses to cover services beyond the therapy cap, it could do so.

Audits

Q: Is there certain criteria Medicare looks at to determine if an audit needs to be done on an outpatient clinic. I have heard if you use modifier 59 Medicare will audit you?

A: Medicare audits providers if they believe there are abhorrent billing practices in a particular practice. The use of the 59 modifier alone does not necessarily lead to an audit on its own. However, if it appears that it is being used excessively or inappropriately the carrier may decide to conduct an audit.

Medicare Advantage

Q: Do Medicare fee for service rules and regulations apply to Medicare Advantage plans (private HMO plans offered to Medicare beneficiaries)?

A: Most of the rules and regulations that apply to the fee for service program do **not** apply to Medicare Advantage Plans. However, a Medicare Advantage plan must provide at a minimum the same benefits to the Medicare beneficiary as would be covered under the Medicare fee for service program.